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## Life-Sustaining Treatment Law: A Model for Balancing a Woman's Reproductive Rights with a Pharmacist's Conscientious Objection

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# LIFE-SUSTAINING TREATMENT LAW: A MODEL FOR BALANCING A WOMAN'S REPRODUCTIVE RIGHTS WITH A PHARMACIST'S CONSCIENTIOUS OBJECTION

**Abstract:** In recent years, there have been several incidents where pharmacists refused to dispense prescriptions for emergency contraception, as well as other types of contraceptives, because of their ethical, moral, or religious beliefs. State law has attempted to address this problem in various ways, but frequently fails to balance adequately the rights of a woman to access lawful contraceptive prescriptions against a pharmacist's right to conscientiously object. This Note argues that pharmacist refusal laws should seek guidance from a similar conflict in the life-sustaining treatment context. Life-sustaining treatment law permits a health care provider to refuse to comply with a patient's decision regarding life-sustaining treatment, but imposes additional duties on the health care provider who does so. These additional duties—requiring the health care provider to notify the patient of its policy in advance and transfer the patient to another health care facility—prevent both the patient's and health care provider's rights from being compromised. The Note concludes that analogous transfer and notice requirements should be placed on pharmacists who conscientiously object to dispensing contraceptive prescriptions.

## INTRODUCTION

In 2002, a woman entered the pharmacy at a Kmart store in Menomonee, Wisconsin to refill her birth control prescription.<sup>1</sup> The only pharmacist on duty refused to refill it because of his religious beliefs.<sup>2</sup> He also refused to transfer the prescription to a nearby pharmacy.<sup>3</sup> As a result, the woman was forced to wait two days to receive her prescription, exposing her to an increased risk of pregnancy.<sup>4</sup> Although

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<sup>1</sup> Sarah Sturmon Dale, *Can a Pharmacist Refuse to Dispense Birth Control?*, TIME, June 7, 2004, at 22.

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> See *id.*; see also Kelsey C. Brodsho, Recent Developments, *Patient Expectations and Access to Prescription Medication Are Threatened by Pharmacist Conscience Clauses*, 7 MINN. J. L. SCI. &

the Wisconsin Pharmacy Examining Board reprimanded the pharmacist, this was not an isolated incident—pharmacists have declined to fill birth control prescriptions because of their ethical, moral, or religious beliefs in several other states.<sup>5</sup> There have been reports of similar incidents in California, Washington, Georgia, Illinois, Louisiana, Massachusetts, Texas, New Hampshire, Ohio, and North Carolina.<sup>6</sup>

State legislation deals with this issue in various ways.<sup>7</sup> For example, four states—Arkansas, Georgia, Mississippi, and South Dakota—have so-called “pharmacist refusal laws” explicitly allowing pharmacists to refuse to dispense contraceptive prescriptions because of their religious, moral, or ethical beliefs.<sup>8</sup> Illinois, on the other hand, explic-

TECH. 327, 331 (2005) (recounting the Wisconsin incident); Holly Teliska, Recent Development, *Obstacles to Access: How Pharmacist Refusal Clauses Undermine the Basic Health Care Needs of Rural and Low-Income Women*, 20 BERKELEY J. GENDER L. & JUST. 229, 229 (2005) (same).

<sup>5</sup> See Amanda Paulson, *Culture Wars Hit Local Pharmacy*, CHRISTIAN SCIENCE MONITOR, Apr. 8, 2005, at 1 (reporting several instances of pharmacists refusing to dispense contraceptives and “morning-after” pills on moral or religious grounds); Kimberlee Roth, *Pharmacists, Doctors Refuse to Dispense Pill on Moral Grounds*, CHI. TRIB., Nov. 17, 2004, at C1 (same); Rob Stein, *Pharmacists’ Rights at Front of New Debate*, WASH. POST, Mar. 28, 2005, at A1 (same). See generally *In re Disciplinary Proceedings Against Neil T. Noesen*, No. LS0310091PHM (Wis. Pharmacy Examining Bd. April 13, 2005), <http://drl.wi.gov/dept/decisions/docs/0405070.htm> (reprimanding the pharmacist for failing to inform the pharmacy of his refusal to transfer oral contraceptives to another pharmacy and requiring him to notify future employers of his objection prior to providing pharmacy services).

<sup>6</sup> See Paulson, *supra* note 5, at 1; Stein, *supra* note 5, at A1.

<sup>7</sup> Compare ARK. CODE ANN. § 20-16-304(4) (West 2005) (exempting pharmacists as well as doctors from being required to dispense contraceptive prescriptions when the refusal is based on religious or conscientious objection), MISS. CODE ANN. §§ 41-107-3(a), (b), -5(1) (2005) (stating that no health care provider, including pharmacists, shall be required to participate in a health care service that violates his or her conscience), S.D. CODIFIED LAWS § 36-11-70 (2004) (declaring that no pharmacist will be required to dispense medication if there is reason to believe it will be used to cause an abortion), and GA. COMP. R. & REGS. 480-5-.03(n) (2001) (stating that a pharmacist’s refusal to fill a prescription based upon ethical or moral beliefs will not be considered unprofessional conduct), with CAL. BUS. & PROF. CODE § 733(b)(3) (West Supp. 2006) (allowing a pharmacist to refuse to dispense a drug on religious, moral, or ethical grounds only if the pharmacist notifies his or her employer beforehand in writing and only if protocols are in place to ensure that the patient has timely access to the drug), and ILL. ADMIN. CODE tit. 68, § 1330.91 (2005) (requiring a pharmacy to dispense valid prescriptions for contraceptives without delay, unless the contraceptive is out of stock, in which case the pharmacy must provide an alternative drug or transfer the prescription to another pharmacy).

<sup>8</sup> See ARK. CODE ANN. § 20-16-304(4); MISS. CODE ANN. §§ 41-107-3(a), (b), -5(1); S.D. CODIFIED LAWS § 36-11-70; GA. COMP. R. & REGS. 480-5-.03(n). This Note will refer to laws that allow health care providers generally, as opposed to pharmacists specifically, to refuse to perform based on religious, moral, or ethical objections, as “health care provider refusal laws.”

itly does not allow pharmacists to refuse to dispense contraception.<sup>9</sup> In 2005, in response to an incident in downtown Chicago where a pharmacist at a drugstore refused to give emergency contraception to two women, Governor Rod Blagojevich made permanent a temporary order requiring Illinois pharmacies to dispense all prescriptions for emergency contraception.<sup>10</sup> Under the law, any pharmacy in the state that sells contraceptives approved by the U.S. Food and Drug Administration (the "FDA") must fill all contraceptive prescriptions.<sup>11</sup> If the contraceptive is not in stock, the pharmacy must provide an alternative drug, order the drug, or transfer the prescription to another local pharmacy.<sup>12</sup>

California also restricts a pharmacist's right to refuse to dispense prescriptions to which he or she is ethically, morally, or religiously opposed.<sup>13</sup> In order to refuse to dispense a prescription, the pharmacist must first notify his or her employer in writing of the drugs that he or she objects to dispensing.<sup>14</sup> The pharmacist will then only be permitted to refuse to dispense the prescription if the employer can reasonably accommodate this refusal without creating undue hardship on the employer.<sup>15</sup> The employer is also required to ensure that the patient has timely access to the drug, despite the pharmacist's refusal to dispense it.<sup>16</sup>

Although the specific issue of a pharmacist's right to refuse to dispense contraception is relatively new, the larger debate over whether a health care provider can refuse to perform or provide services because of moral or religious objections has swirled for years.<sup>17</sup> Most states have

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<sup>9</sup> ILL. ADMIN. CODE tit. 68, § 1330.91.

<sup>10</sup> See ILL. ADMIN. CODE tit. 68, § 1330.91; John Chase, *Legislators Back Edict on Birth Pills*, CHI. TRIB., Aug. 17, 2005, at 3; Paulson, *supra* note 5, at 1.

<sup>11</sup> ILL. ADMIN. CODE tit. 68, § 1330.91.

<sup>12</sup> *Id.*

<sup>13</sup> CAL. BUS. & PROF. CODE § 733(b)(3) (West Supp. 2006).

<sup>14</sup> *Id.*

<sup>15</sup> *Id.* (noting that "undue hardship" shall have the same meaning as applied to "undue hardship" under subdivision (l) of section 12940 of California's Government Code). Section 12940 cross-references to the definition of "undue hardship" in Section 12926. CAL. GOV'T CODE § 12940 (West 2005). Subsection (s) of section 12926 defines "undue hardship" as an action requiring significant difficulty or expense, when considered in light of the financial resources of the facility involved, among other factors. CAL. GOV'T CODE § 12926(s) (West 2005).

<sup>16</sup> CAL. BUS. & PROF. CODE § 733(b)(3).

<sup>17</sup> Adam Sonfield, *Rights v. Responsibilities: Professional Standards and Provider Refusals*, GUTTMACHER REP'T ON PUB. POL'Y, Aug. 2005, at 7, 7, available at <http://www.guttmacher.org/pubs/tgr/08/3/gr080307.pdf> (noting that the debate over the right of pharmacists to refuse to dispense contraception is new but the larger issue of whether health care provid-

laws dating back to the 1970s that explicitly allow doctors, nurses, or health care institutions to refuse to provide or participate in certain types of reproductive health care, such as abortion and contraceptive services.<sup>18</sup> The debate continues, however, as to how far these health care provider refusal laws should be expanded.<sup>19</sup> Much of this debate centers on pharmacists, who were not explicitly included in the early refusal laws and are now insisting that they too have a right to conscientiously object.<sup>20</sup> This issue is especially pertinent because controversial advances in medical technology, such as emergency contraception, have met both with high demand from patients and moral objections from health care providers.<sup>21</sup>

This Note addresses pharmacists' right to conscientiously object to dispensing contraception. Part I discusses the right of women to access contraception and abortion services in the United States and the limitations placed on those rights.<sup>22</sup> Part II addresses the history of health care provider refusal laws, the factors contributing to the expansion of refusal laws, and the application of these laws to life-sustaining treatment decisions.<sup>23</sup> Part III focuses on efforts to expand health care provider refusal laws to pharmacists and recent legislation

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ers can refuse to perform services because of their religious convictions is not). This Note uses "health care provider" as a general term to refer to any individual person, facility, or organization involved in the health care field.

<sup>18</sup> See, e.g., ARK. CODE ANN. § 20-16-304(4), (5) (West 2005); COLO. REV. STAT. § 25-6-102(9) (2004); DEL. CODE ANN. tit. 24, § 1791 (1997); FLA. STAT. ANN. § 381.0051(6) (West 2002); IOWA CODE ANN. § 146.1 (West 2005); ME. REV. STAT. ANN. tit. 22, § 1903(4) (2004); NEB. REV. STAT. ANN. § 28-337 (LexisNexis 2003); OR. REV. STAT. § 435.225 (2003); 18 PA. CONS. STAT. ANN. § 3213(d) (West 2000); S.C. CODE ANN. § 44-41-40 (2002); TENN. CODE ANN. § 68-34-104(5) (2001); W. VA. CODE ANN. § 16-2B-4 (LexisNexis 2001); WYO. STAT. ANN. § 42-5-101(d) (2005).

<sup>19</sup> See, e.g., Adam Sonfield, *New Refusal Clauses Shatter Balance Between Provider 'Conscience,' Patient Needs*, GUTTMACHER REP'T ON PUB. POL'Y, Aug. 2004, at 1, 1-3, available at <http://www.guttmacher.org/pubs/tgr/07/3/gr070301.pdf> (contending that more recent movements to expand health care refusal laws, including such a movement by pharmacists, threaten the balance between allowing for providers' conscientious objections and protecting patients' access to health care services); Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177, 177 (1993) (arguing that current health care refusal laws provide inadequate protection for health care providers with conscientious objections and proposing legislation expanding the right of health care providers to conscientiously object to performing or providing health care services).

<sup>20</sup> See Pharmacists for Life International, Legal News and Information for Pro-Life Pharmacists of Conscience, <http://www.pfli.org/main.php?pfli=legal> (last visited Mar. 24, 2006) [hereinafter Pharmacists for Life] (advocating for an expansion of conscience clauses to pharmacists).

<sup>21</sup> See Sonfield, *supra* note 19, at 1.

<sup>22</sup> See *infra* notes 28-74 and accompanying text.

<sup>23</sup> See *infra* notes 75-190 and accompanying text.

addressing this issue.<sup>24</sup> Part IV discusses the inadequacies of current pharmacist refusal laws, which fail to balance adequately a pharmacist's right to conscientiously object against a woman's right to access contraception.<sup>25</sup> This Part then looks to life-sustaining treatment court decisions and legislation to provide a model for balancing these competing interests and concludes that current laws should include transfer and notice requirements.<sup>26</sup> Although relevant, this Note will not address possible First Amendment arguments based on the Free Exercise Clause or the Establishment Clause in relation to a pharmacist's right to conscientiously object.<sup>27</sup>

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<sup>24</sup> See *infra* notes 191–235 and accompanying text.

<sup>25</sup> See *infra* notes 236–250 and accompanying text.

<sup>26</sup> See *infra* notes 251–283 and accompanying text. Several authors have explored aspects of pharmacist refusal laws, but have not utilized the approach that courts have taken towards life-sustaining treatment options as a template for addressing the issue. See generally Lorraine Schmall, *Birth Control as a Labor Law Issue*, 13 DUKE J. GENDER L. & POL'Y 139 (2006) (arguing that legal obstructions to birth control, such as health care provider refusal laws, frustrate gender equality in the workplace and hence raise labor law issues); Amy Bergquist, Note, *Pharmacist Refusals: Dispensing (With) Religious Accommodation Under Title VII*, 90 MINN. L. REV. 1073 (2006) (analyzing pharmacist refusals under the religious accommodation requirements of Title VII); Bryan A. Dykes, Note, *Proposed Rights of Conscience Legislation: Expanding to Include Pharmacists and Other Health Care Providers*, 36 GA. L. REV. 565 (2002) (proposing that state legislatures expand and strengthen health care provider refusal laws as applied to pharmacists and other health care providers so as to protect the moral integrity and personal autonomy of health care providers); Minh N. Nguyen, Comment, *Refusal Clauses & Pro-Life Pharmacists: How Can We Protect Ourselves from Them?*, 8 SCHOLAR 251 (2006) (discussing the effect of pharmacist refusal laws on women's reproductive freedom, health, and rights); Teliska, *supra* note 4 (arguing that broad pharmacist refusal laws will adversely affect low-income women and rural women in particular).

<sup>27</sup> In *Employment Division, Department of Human Resources v. Smith*, the U.S. Supreme Court upheld the state's denial of unemployment compensation for employees who had ingested illegal drugs—even though the employees had ingested the drug as part of a religious practice—because the law prohibiting the use of the drug was generally applicable. 492 U.S. 872, 890 (1990). The Court held that generally applicable laws that prohibit the exercise of religion do not offend the Free Exercise Clause of the First Amendment. *Id.* at 878–79. As such, it is possible that the Constitution would not require exemption for pharmacists who religiously object to dispensing contraceptives from generally applicable laws requiring contraceptive prescriptions to be filled. See *id.* Additionally, the Court noted that religious accommodation and exemption should be left to the political process. *Id.* at 890. Moreover, a health care provider's conscientious objection may also be based on ethical or moral objections, rather than religious objections, in which case the Free Exercise Clause of the First Amendment would presumably not apply. See, e.g., *Valley Hosp. Ass'n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 972 (Alaska 1997); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 632 (Mass. 1986); *Delio v. Westchester County Med. Ctr.*, 516 N.Y.S.2d 677, 680 (App. Div. 1987).

On the other hand, the Supreme Court has also recognized that the government may accommodate religious practices without violating the Establishment Clause. *Corp. of Presiding Bishop of Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327, 334 (1987). For example, in *Corp. of Presiding Bishop of Church of Jesus Christ of Latter-Day Saints v.*

## I. HISTORY OF ACCESS TO CONTRACEPTION AND ABORTION

A. *History of Access to Contraception*

The U.S. Supreme Court first recognized a right to be free from governmental intrusion with regard to contraceptive use in *Griswold v. Connecticut* in 1965.<sup>28</sup> The statute at issue in *Griswold* made the use of contraception illegal, as well as the assistance and counseling of that use.<sup>29</sup> The Court held that a state could not prohibit contraceptive use between married couples because such activity fell within a zone of privacy guaranteed by the Constitution.<sup>30</sup> This zone of privacy was a penumbral right emanating from several fundamental constitutional guarantees in various amendments, including the First, Third, Fourth, Fifth, and Ninth Amendments.<sup>31</sup>

In particular, *Griswold* noted that contraceptive use was part of the fundamental right of privacy surrounding the marital relationship.<sup>32</sup> While the Court acknowledged that other types of contraception regulation could be upheld (such as regulations regarding manufacture or sales), a regulation banning contraceptive use altogether was unnecessarily broad and violated the fundamental right of married couples to make a private decision to use contraceptives.<sup>33</sup>

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*Amos*, the Court held that a statutory exemption allowing religiously-affiliated organizations to be exempt from a generally applicable law prohibiting religious discrimination in employment did not violate the Establishment Clause. *Id.* at 334–40. Thus, it is plausible that refusal clauses allowing for religious exemptions from performing or participating in health services similarly do not violate the Establishment Clause. *See id.* Moreover, refusal clauses also allow exemption for non-religious purposes, such as conscientious, moral, or ethical objections, and thus would presumably not violate the Establishment Clause. *See, e.g.,* CAL. HEALTH & SAFETY CODE § 123420(a) (West 1996); KY. REV. STAT. ANN. § 311.633(3) (LexisNexis 2001); MISS. CODE ANN. §§ 41-107-3(a), (b), -5(1) (2005). Additionally, some refusal clauses simply allow health care providers to refuse to participate in health care services, without specifying the reason for the health care provider's objections. *See, e.g.,* ALA. CODE § 22-8A-8(a) (LexisNexis 1997); ARK. CODE ANN. § 20-16-601(a), (b) (2005); MICH. COMP. LAWS ANN. § 333.20181 (West 2001); *see also* Katherine A. White, *Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights*, 51 STAN. L. REV. 1703, 1724–33 (1999) (discussing Free Exercise and Establishment Clauses as applied to state regulations of religious health care providers).

<sup>28</sup> 381 U.S. 479, 485–86 (1965).

<sup>29</sup> *Id.* at 480.

<sup>30</sup> *Id.* at 485–86.

<sup>31</sup> *Id.* at 484.

<sup>32</sup> *Id.* at 485–86.

<sup>33</sup> *Griswold*, 381 U.S. at 485.

In 1972, the Supreme Court in *Eisenstadt v. Baird* extended the right to use contraceptives to unmarried persons.<sup>34</sup> A Massachusetts law made it illegal to distribute contraceptives to unmarried persons, while allowing distribution to married persons.<sup>35</sup> While the Court struck down the law as violating the Equal Protection Clause in treating married and unmarried persons differently, it also observed that the right to privacy associated with using contraceptives is a fundamental right as well.<sup>36</sup> In particular, the Court noted that the right to privacy grants the individual freedom from governmental intrusion into fundamentally personal decisions, such as whether to bear or beget a child.<sup>37</sup>

In its 1977 decision in *Carey v. Population Services International*, the Supreme Court reaffirmed the reasoning and holdings of both *Griswold* and *Eisenstadt*.<sup>38</sup> In *Carey*, a New York statute not only prohibited the distribution of contraceptives to anyone under the age of sixteen and the advertisement or display of contraceptives, but also prohibited anyone other than a licensed pharmacist from distributing contraceptives to persons sixteen or older.<sup>39</sup> The Court again stated that the decision to bear or beget a child is at the very heart of the choices that are constitutionally protected by the right of privacy.<sup>40</sup> The Court then concluded that the statute's prohibitions on contraceptive use, distribution, and advertisement were unconstitutional because they did not serve any compelling state interests that justified burdening such a fundamental right.<sup>41</sup>

### B. History of Access to Abortion

The Supreme Court extended the right of privacy to abortion in 1973, in the landmark case of *Roe v. Wade*.<sup>42</sup> In *Roe*, the Court struck down a statute that prohibited abortions except when necessary to save the life of the mother.<sup>43</sup> The Court held that the fundamental right to privacy rooted in the Due Process Clause of the Fourteenth

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<sup>34</sup> 405 U.S. 438, 453–55 (1972).

<sup>35</sup> *Id.* at 442.

<sup>36</sup> *Id.* at 453–55.

<sup>37</sup> *Id.* at 453.

<sup>38</sup> 431 U.S. 678, 685 (1977).

<sup>39</sup> *Id.* at 681.

<sup>40</sup> *Id.* at 685.

<sup>41</sup> *Id.* at 690–91, 694–99, 701–02.

<sup>42</sup> 410 U.S. 113, 153 (1973).

<sup>43</sup> *Id.* at 117–18, 166.



Amendment was broad enough to encompass a woman's decision to terminate her pregnancy.<sup>44</sup> The Court also held that the state had compelling interests in both the health of the mother and in the potential life of the fetus.<sup>45</sup> These interests, however, became compelling at various stages in the pregnancy, which the Court divided into three-month periods called trimesters.<sup>46</sup> The state's interest in the health of the mother was paramount during the first trimester; therefore, the state could not regulate abortion during this period.<sup>47</sup> After the first trimester, the interest in the potential life rose in importance and the state could regulate abortion in ways that were reasonably related to maternal health.<sup>48</sup> After the point of viability, which the Court placed at the end of the second trimester, the state could choose to regulate or even proscribe abortion, except when necessary to preserve the life or health of the mother.<sup>49</sup>

In 1992, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Supreme Court revisited the right to access an abortion in examining various requirements under a Pennsylvania abortion statute.<sup>50</sup> In so doing, the Court upheld the central holding of *Roe*, recognizing the fundamental right of a woman to choose to have an abortion.<sup>51</sup> The Court, however, rejected *Roe's* approach of balancing the competing interests in a pregnancy through a trimester framework.<sup>52</sup> Instead, the Court held that state regulation of abortion is unconstitutional when it places an undue burden on a woman's choice to have an abortion.<sup>53</sup> Thus, a state may regulate abortions to promote its interest in potential life and the health of the mother at any point in the pregnancy, so long as such regulation does not amount to an undue

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<sup>44</sup> *Id.* at 153.

<sup>45</sup> *Id.* at 163-64.

<sup>46</sup> *Id.* at 162-64.

<sup>47</sup> See *Roe*, 410 U.S. at 164-65.

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> 505 U.S. 833, 844 (1992). The five provisions at issue in the Pennsylvania statute were: (1) a requirement that a woman seeking an abortion give her informed consent prior to the procedure; (2) a provision mandating informed consent of one parent for a minor to obtain an abortion, but also providing for a judicial bypass procedure; (3) a requirement that, unless certain exceptions apply, a married woman seeking an abortion must sign a statement indicating that she has notified her husband; (4) an exemption from the foregoing requirements based upon a "medical emergency"; and (5) certain reporting requirements for facilities providing abortion services. *Id.*

<sup>51</sup> *Id.* at 871.

<sup>52</sup> *Id.* at 873.

<sup>53</sup> *Id.* at 874.

burden on a woman's access to an abortion.<sup>54</sup> The Court reaffirmed that a state may choose to forbid abortions, but only after the point of viability.<sup>55</sup> Additionally, even though a state may proscribe abortions after viability, there must still be an exception to allow for an abortion when necessary for the preservation of the life or health of the mother.<sup>56</sup>

### C. *Limitations on the Federal Constitution Abortion Right*

After the Supreme Court's decision in *Roe* holding that a woman has a fundamental right to have an abortion, some lower courts inferred that public hospitals, as state actors, could not refuse to perform elective abortions because such refusal violated a woman's constitutional right to an abortion.<sup>57</sup> For example, in *Doe v. Hale Hospital*, a public hospital owned by the city of Haverhill, Massachusetts had a policy of allowing therapeutic abortions, but forbidding elective abortions.<sup>58</sup> The U.S. Court of Appeals for the First Circuit held that a public medical facility may not forbid elective abortions so long as it offers medically indistinguishable procedures, such as therapeutic abortions.<sup>59</sup> Likewise, in *Doe v. Charleston Area Medical Center*, the Fourth Circuit held that Charleston Area Medical Center's policy of prohibiting abortions except when necessary to save the life of the mother conflicted with the holding in *Roe*, and thus was unconstitutional.<sup>60</sup>

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<sup>54</sup> *Id.* at 878.

<sup>55</sup> *Casey*, 505 U.S. at 879.

<sup>56</sup> *Id.* Subsequent Supreme Court cases have reiterated this health exception requirement. See *Ayotte v. Planned Parenthood of N. New England*, 126 S. Ct. 961, 967 (2006); *Stenberg v. Carhart*, 530 U.S. 914, 930 (2000).

<sup>57</sup> See *Doe v. Charleston Area Med. Ctr.*, 529 F.2d 638, 643-45 (4th Cir. 1975); *Doe v. Hale Hosp.*, 500 F.2d 144, 147 (1st Cir. 1974). Because the Fourteenth Amendment ostensibly only applies to the states, as opposed to persons or private organizations, the Court's rulings on abortion do not apply to a privately-funded hospital. See U.S. CONST. amend. XIV; see also *Hale Hosp.*, 500 F.2d at 147 (implying that a privately-funded hospital would not be subject to *Roe*). Under the concept of state action, however, an organization that receives significant public funding or is heavily regulated by the state may be required to abide by the Constitution to the same degree as the state. See *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974) (stating that there must be a "sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself"). The Court, however, has sharply limited the degree to which even a public hospital is currently required to provide abortions. See *infra* notes 61-68 and accompanying text.

<sup>58</sup> 500 F.2d at 145.

<sup>59</sup> *Id.* at 147.

<sup>60</sup> *Doe*, 529 F.2d at 643-45.

The Supreme Court, however, has since rejected the argument that states are required either to provide elective abortions through public facilities or to fund elective abortions through public funds.<sup>61</sup> For example, in its 1977 decision in *Maier v. Roe*, the Court clarified that *Roe* did not grant an unqualified right to an abortion from the state; rather, it protected women from unduly burdensome interference with a woman's freedom to choose to terminate a pregnancy.<sup>62</sup> Thus, a state could choose to favor a policy of childbirth over abortion and implement that policy through the allocation of funds without creating an unduly burdensome interference with a woman's right to choose an abortion.<sup>63</sup> Women still had the option of using private sources for abortion services.<sup>64</sup>

Additionally, in 1989, in *Webster v. Reproductive Health Services*, the Court held that nothing in the Constitution required states to enter or remain in the abortion business or entitled private physicians and patients to access public facilities for the performance of abortions.<sup>65</sup> In *Webster*, a Missouri statute prohibited the use of public employees and facilities to perform or assist in elective abortions.<sup>66</sup> As in *Maier*, the state's decision to use public facilities and staff to encourage childbirth over abortion did not place an obstacle in the path of a woman who chooses to have an abortion.<sup>67</sup> A woman could still choose to have an abortion, the Court reasoned, even though she had to rely on a privately employed physician to perform the procedure.<sup>68</sup>

#### D. *Broader Abortion Rights Under State Constitutions*

Supreme Court decisions thus interpreted the federal Constitution as not requiring states to fund or provide abortion services.<sup>69</sup> Some state courts, however, have held that a state actor's denial of abortion services or a state's refusal to fund abortion services violates a woman's right to choose an abortion under their state constitu-

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<sup>61</sup> *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 509-10 (1989); *Maier v. Roe*, 432 U.S. 464, 474 (1977).

<sup>62</sup> *Maier*, 432 U.S. at 473-74. At issue was a Connecticut statute that limited state Medicaid benefits to abortions that were necessary to save the life of the mother. *Id.* at 466.

<sup>63</sup> *Id.* at 473-74.

<sup>64</sup> *Id.* at 474.

<sup>65</sup> 492 U.S. at 509-10.

<sup>66</sup> *Id.* at 501.

<sup>67</sup> *Id.* at 509-10.

<sup>68</sup> *Id.*

<sup>69</sup> See *Webster*, 492 U.S. at 509-10; *Maier*, 432 U.S. at 474.

tions.<sup>70</sup> For example, in *Valley Hospital Ass'n v. Mat-Su Coalition for Choice*, the Supreme Court of Alaska held that a quasi-public hospital, as a state actor, violated a woman's fundamental right to an abortion found in Alaska's state constitution by refusing to perform elective abortions.<sup>71</sup> By holding that a quasi-public institution was a state actor subject to the limitations in the state constitution, the court necessarily implied that a public hospital would be similarly subjected to constitutional limitations as a state actor.<sup>72</sup>

Additionally, in *Committee to Defend Reproductive Rights v. Myers*, the Supreme Court of California held that the state's refusal to fund elective abortions under Medi-Cal, California's Medicaid program, violated California's state constitution.<sup>73</sup> The court reasoned that although the state had no constitutional obligation to pay for medical care for the poor, once it decided to provide such benefits, it could not withhold these benefits from otherwise qualified individuals simply because they chose to exercise their constitutional right to an abortion.<sup>74</sup>

## II. HISTORY OF HEALTH CARE PROVIDER REFUSAL LAWS

### A. Initial Wave of Health Care Provider Refusal Laws

Health care provider refusal laws initially appeared in the 1970s as a general response to the constitutional requirements posed by the U.S. Supreme Court's 1973 decision of *Roe v. Wade*, and as a specific response to a court's issuance of a preliminary injunction requiring a Catholic hospital to perform a sterilization procedure.<sup>75</sup> On October 27, 1972, in *Taylor v. St. Vincent's Hospital*, the U.S. District Court for the District of Montana issued a preliminary injunction that required a Catholic hospital—which was considered a state actor by virtue of

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<sup>70</sup> *Valley Hosp. Ass'n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 971 (Alaska 1997); *Comm. to Defend Reprod. Rights v. Myers*, 625 P.2d 779, 799 (Cal. 1981).

<sup>71</sup> 948 P.2d at 971.

<sup>72</sup> *See id.* at 969–70.

<sup>73</sup> 625 P.2d at 798–99.

<sup>74</sup> *Id.*

<sup>75</sup> *See Roe v. Wade*, 410 U.S. 113, 153 (1973); *Taylor v. St. Vincent's Hosp.*, 369 F. Supp. 948, 950–51 (D. Mont. 1973), *aff'd*, 523 F.2d 75 (9th Cir. 1975); *see also* ACLU REPRODUCTIVE FREEDOM PROJECT, ACLU, RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS 1, 1 (2002), available at <http://www.acu.org/FilesPDFs/ACF911.pdf> [hereinafter ACLU REPORT] (discussing the history of refusal clauses in the reproductive health context and proposing a framework for reconciling the competing interests of health care providers' conscientious objections and providing reproductive health care to patients).

receiving certain federal funds—to perform a sterilization procedure on a woman.<sup>76</sup> Despite the fact that performing a sterilization procedure was against the Catholic hospital's religious beliefs, the court reasoned that, as a state actor, the hospital could not refuse to perform the sterilization without infringing a woman's constitutional right to receive such services.<sup>77</sup>

In June 1973, less than a year after the District of Montana's preliminary injunction, Congress passed the Church Amendment.<sup>78</sup> The Church Amendment prevented health care entities that received certain federal funds and individuals employed by those entities from being forced to perform certain reproductive services to which those entities and their employees were morally or religiously opposed.<sup>79</sup> The Church Amendment opened the door for states to follow with similar laws permitting health care providers to refuse to perform reproductive services.<sup>80</sup>

Current health care provider refusal laws reflect this initial focus on allowing providers to refuse to perform reproductive services.<sup>81</sup> As such, most states have a health care provider refusal law referring specifically to abortion procedures.<sup>82</sup> Some state laws simply declare that a health care facility is not required to permit abortions within

<sup>76</sup> See 369 F. Supp. at 950–51.

<sup>77</sup> See *id.* at 950.

<sup>78</sup> See Pub. L. No. 93-45, 87 Stat. 91 (1973) (current version at 42 U.S.C. § 300a-7 (2000)); *Taylor*, 369 F. Supp. at 950.

<sup>79</sup> Pub. L. No. 93-45, 87 Stat. 91 (1973) (current version at 42 U.S.C. § 300a-7 (2000)).

<sup>80</sup> See ACLU REPORT, *supra* note 75, at 1.

<sup>81</sup> See, e.g., ARK. CODE ANN. § 20-16-304(4), (5) (West 2005); COLO. REV. STAT. § 25-6-102(9) (2004); DEL. CODE ANN. tit. 24, § 1791 (1997); FLA. STAT. ANN. § 381.0051(6) (West 2002); IOWA CODE ANN. § 146.1 (West 2005); ME. REV. STAT. ANN. tit. 22, § 1903(4) (2004); NEB. REV. STAT. ANN. § 28-337 (LexisNexis 2003); OR. REV. STAT. § 435.225 (2003); 18 PA. CONS. STAT. ANN. § 3213(d) (West 2000); S.C. CODE ANN. § 44-41-40 (2002); TENN. CODE ANN. § 68-34-104(5) (2001); W. VA. CODE ANN. § 16-2B-4 (LexisNexis 2001); WYO. STAT. ANN. § 42-5-101(d) (2005).

<sup>82</sup> See, e.g., ALASKA STAT. § 18.16.010(b) (2004); ARIZ. REV. STAT. ANN. § 36-2151 (2003); CAL. HEALTH & SAFETY CODE § 123420(a)–(c) (West 1996); COLO. REV. STAT. § 18-6-104 (2004); IDAHO CODE ANN. § 18-612 (2004); KAN. STAT. ANN. § 65-443 (2002); ME. REV. STAT. ANN. tit. 22, §§ 1591, 1592 (2004); MICH. COMP. LAWS ANN. § 333.20181 (West 2001); MO. ANN. STAT. § 197.032 (West 2004); NEB. REV. STAT. §§ 28-337, 338; NEV. REV. STAT. ANN. § 632.475 (LexisNexis 2004); N.Y. CIV. RIGHTS LAW § 79-i (McKinney 1992); N.C. GEN. STAT. § 14-45.1(e), (f) (2003); OKLA. STAT. ANN. tit. 63, § 1-741 (West 2004); OR. REV. STAT. § 435.485 (2003); 18 PA. CONS. STAT. ANN. § 3213(d); TENN. CODE ANN. § 39-15-204 (2003); W. VA. CODE ANN. § 16-2F-7 (LexisNexis 2001).

the facility.<sup>83</sup> In several states, however, only private or religiously-affiliated health care facilities are permitted to decline to perform abortions.<sup>84</sup> Additionally, most states allow an individual person, employee, or health care provider to refuse to perform or participate in abortion procedures.<sup>85</sup> A number of states also require that the person who objects to performing or participating in the procedure either advise the facility of his or her objection verbally or file a written statement with the facility stating his or her objection.<sup>86</sup>

Some states also allow individual health care providers or facilities to refuse to provide contraceptive services.<sup>87</sup> As with refusal laws relating to abortion, some states limit the right to refuse to provide contraceptive services to private institutions.<sup>88</sup> In contrast, some states specifically permit state employees or facilities to refuse to provide contraceptive services.<sup>89</sup>

### *B. Lower Courts' Interpretation of Health Care Provider Refusal Laws*

Lower courts have interpreted health care provider refusal clauses in a variety of ways.<sup>90</sup> One court held that the constitutional

<sup>83</sup> See, e.g., ALASKA STAT. § 18.16.010(b); ARK. CODE ANN. § 20-16-601(b) (West 2005); DEL. CODE ANN. tit. 24, § 1791(b); MICH. COMP. LAWS ANN. § 333.20181; N.C. GEN. STAT. § 14-45.1(f); OHIO REV. CODE ANN. § 4731.91(A), (B) (West 2004).

<sup>84</sup> See, e.g., CAL. HEALTH & SAFETY CODE § 123420(c); IOWA CODE ANN. § 146.2 (West 2005), OKLA. STAT. ANN. tit. 63, § 1-741(A); S.C. CODE ANN. § 44-41-40; UTAH CODE ANN. § 76-7-306(2) (2003); WYO. STAT. ANN. § 35-6-105 (2005).

<sup>85</sup> See, e.g., ALASKA STAT. § 18.16.010(b); ARIZ. REV. STAT. ANN. § 36-2151; ARK. CODE ANN. § 20-16-601(a) (West 2005); CAL. HEALTH & SAFETY CODE § 123420(a); COLO. REV. STAT. § 18-6-104; DEL. CODE ANN. tit. 24, § 1791(a); IDAHO CODE ANN. § 18-612; IOWA CODE ANN. § 146.1; KAN. STAT. ANN. § 65-443; ME. REV. STAT. ANN. tit. 22, § 1591; MO. REV. STAT. § 197.032(1); N.Y. CIV. RIGHTS LAW § 79-i(1); N.C. GEN. STAT. § 14-45.1(e); N.D. CENT. CODE § 23-16-14 (2002); OKLA. STAT. ANN. tit. 63, § 1-741(B); OR. REV. STAT. § 435.485; 18 PA. CONS. STAT. ANN. § 3213(d); S.C. CODE ANN. § 44-41-40; WYO. STAT. ANN. § 35-6-106 (2005).

<sup>86</sup> See, e.g., ARIZ. REV. STAT. ANN. § 36-2151 (2004); CAL. HEALTH & SAFETY CODE § 123420(a); COLO. REV. STAT. § 18-6-104; IDAHO CODE ANN. § 18-612; S.C. CODE ANN. § 44-41-40.

<sup>87</sup> See, e.g., ARK. CODE ANN. § 20-16-304(4), (5) (West 2005); COLO. REV. STAT. § 25-6-102(9) (2004); ME. REV. STAT. ANN. tit. 22, § 1903 (2004); OR. REV. STAT. § 435.225 (2003); TENN. CODE ANN. § 68-34-104(5) (2001); W. VA. CODE ANN. § 16-2B-4 (LexisNexis 2001); WYO. STAT. ANN. § 42-5-101(d) (2005).

<sup>88</sup> See, e.g., COLO. REV. STAT. § 25-6-102(9); ME. REV. STAT. ANN. tit. 22, § 1903(4); TENN. CODE ANN. § 68-34-104(5).

<sup>89</sup> See, e.g., OR. REV. STAT. § 435.225; W. VA. CODE ANN. § 16-2B-4; WYO. STAT. ANN. § 42-5-101(d).

<sup>90</sup> See, e.g., Valley Hosp. Ass'n v. Mat-Su Coal. for Choice, 948 P.2d 963, 971-72 (Alaska 1997); Brownfield v. Daniel Freeman Marina Hosp., 256 Cal. Rptr. 240, 244-45 (Ct. App. 1989); Kenny v. Ambulatory Ctr. of Miami, Fla., Inc., 400 So. 2d 1262, 1264-66 (Fla. Dist.

right to an abortion trumps the health care provider's statutory right to refusal.<sup>91</sup> In *Valley Hospital Ass'n v. Mat-Su Coalition for Choice*, for example, the Supreme Court of Alaska rejected a quasi-public hospital's invocation of Alaska's refusal law, which provided that a hospital could decline to offer abortions for reasons of moral conscience.<sup>92</sup> The court reasoned that it could not defer to the legislature when a statute led to a violation of a woman's fundamental right to an abortion as embodied in Alaska's constitution.<sup>93</sup> Thus, it held that the refusal law, as applied to the quasi-public hospital in this case, was unconstitutional.<sup>94</sup>

Other courts have narrowly interpreted their health care provider refusal laws by limiting their application to certain individuals or certain medicines.<sup>95</sup> For instance, in *Brownfield v. Daniel Freeman Marina Hospital*, a rape victim sought declaratory and injunctive relief from a Catholic hospital for its failure to provide her with information and access to emergency contraception as part of her treatment.<sup>96</sup> The hospital claimed it was exempt from providing this treatment under the state's Therapeutic Abortion Act, which allowed a religious non-profit hospital to avoid liability for failing to perform or permit the performance of an abortion on its premises.<sup>97</sup> The California Court of Appeal concluded that since emergency contraception prevents rather than terminates a pregnancy, the treatment was not considered an abortion under the meaning of the statute.<sup>98</sup>

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Ct. App. 1981); *Swanson v. St. John's Lutheran Hosp.*, 597 P.2d 702, 709-10 (Mont. 1979); *Spellacy v. Tri-County Hosp.*, Equity No. 77-1788, 1978 WL 3437, at \*3-4 (Pa. Ct. Com. Pl. March 3, 1978).

<sup>91</sup> See *Valley Hosp. Ass'n*, 948 P.2d at 971-72.

<sup>92</sup> *Id.*

<sup>93</sup> *Id.* at 972.

<sup>94</sup> *Id.*

<sup>95</sup> See *Brownfield*, 256 Cal. Rptr. at 244-45; *Spellacy*, 1978 WL 3437, at \*3-4. The *Spellacy* court, in an unreported case, chose to interpret refusal clauses narrowly so as not to allow certain individuals not directly involved in providing the health care service to invoke it. See 1978 WL 3437, at \*3-4. In that case, an admissions clerk refused to admit patients entering the hospital for abortions because of her religious beliefs. *Id.* at \*1. The Court of Common Pleas of Pennsylvania did not allow the clerk to invoke Pennsylvania's health care provider refusal clause. *Id.* at \*3-4. The court reasoned that the refusal clause only allowed individuals directly involved in performing the abortion and whose services were essential to the performance of the procedure to refuse to participate because of their religious beliefs. *Id.* Because the clerk's duties were ancillary to the procedure and merely clerical, she could not be exempted from her admissions duties. *Id.*

<sup>96</sup> 256 Cal. Rptr. at 242.

<sup>97</sup> *Id.* at 244.

<sup>98</sup> *Id.* at 245.

Additionally, at least one court held that even if a health care provider refusal law is written as an absolute, an employer may still terminate an employee for refusing to perform a procedure if accommodating his or her religious beliefs would create an undue hardship on the employer.<sup>99</sup> In *Kenny v. Ambulatory Centre of Miami, Florida, Inc.*, a nurse was demoted after she refused to participate in abortion procedures.<sup>100</sup> Although Florida's refusal law did not require consideration of the hardship on the employer created by the employee's refusal to participate in certain services, the court adopted the federal standard under Title VII of the Civil Rights Act of 1964.<sup>101</sup> This standard required the employer to reasonably accommodate the employee's religious beliefs unless doing so would result in undue hardship.<sup>102</sup> Because a reasonable accommodation of the nurse's beliefs would not have created an undue hardship on the hospital's ability to perform abortions, the nurse rightfully invoked the state's refusal law and was wrongfully terminated.<sup>103</sup>

By contrast, one court held that the language of its state health care provider refusal law gave a hospital employee an unqualified statutory right to refuse to participate in a medical service because of moral objections.<sup>104</sup> In *Swanson v. St. John's Lutheran Hospital*, a nurse refused to participate in a sterilization procedure and was subsequently dismissed from her employment.<sup>105</sup> Because the refusal law did not consider the hardship a hospital might suffer as a result of an employee's conscientious objection, the Supreme Court of Montana in turn did not consider any hardship that might be suffered by the hospital from the nurse's refusal.<sup>106</sup>

### C. Factors Contributing to the Expansion of Health Care Provider Refusal Laws

Beginning in the 1990s, health care provider refusal laws attracted renewed attention as a means to protect health care employ-

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<sup>99</sup> See *Kenny*, 400 So. 2d at 1266.

<sup>100</sup> *Id.* at 1263.

<sup>101</sup> *Id.* at 1264-66.

<sup>102</sup> *Id.* at 1266-67. The court noted that determining whether a good faith effort to reasonably accommodate an employee's religious beliefs had been made and whether the employer had suffered undue hardship in his attempts to do so was a factual determination, to be made on a case-by-case basis. *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> See *Swanson*, 597 P.2d at 710.

<sup>105</sup> *Id.* at 704-05.

<sup>106</sup> *Id.* at 709-10.



ees' conscientious objections to reproductive services.<sup>107</sup> State legislatures expanded the types of procedures covered by these laws as well as the number and types of providers who may invoke them.<sup>108</sup> At least three factors contributed to this renewed pressure: (1) the rise of religious health care systems, (2) the expansion of managed care, and (3) the development of controversial medical technology.<sup>109</sup>

First, religious health care systems have become more significant in the health care provider market.<sup>110</sup> For example, as of September 2005, four of the top ten largest non-profit health care systems were Catholic-owned, including the largest non-profit health care system.<sup>111</sup> Additionally, there are 611 Catholic hospitals in the United States, representing approximately 12% of all hospitals nationwide.<sup>112</sup> Because of its ethical directives that prohibit or limit controversial services such as contraceptive sterilization, in vitro fertilization, prescription or dispensation of contraceptive devices, and abortions, the prevalence of Catholic health care is significant.<sup>113</sup> Moreover, this impact is intensified by the fact that over a quarter of the 611 Catholic

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<sup>107</sup> ACLU REPORT, *supra* note 75, at 1; Sonfield, *supra* note 19, at 1.

<sup>108</sup> ACLU REPORT, *supra* note 75, at 1; Sonfield, *supra* note 19, at 1.

<sup>109</sup> See ACLU REPORT, *supra* note 75, at 1-3; CATHOLICS FOR A FREE CHOICE, CATHOLIC HEALTH CARE UPDATE: THE FACTS ABOUT CATHOLIC HEALTHCARE IN THE UNITED STATES 1-6 (2005), available at [http://www.catholicsforchoice.org/topics/healthcare/documents/2005factsaboutcatholichealthcare\\_000.pdf](http://www.catholicsforchoice.org/topics/healthcare/documents/2005factsaboutcatholichealthcare_000.pdf) [hereinafter CATHOLIC HEALTH CARE]; Rachel Benson Gold, *Conscience Makes a Comeback in the Age of Managed Care*, GUTTMACHER REP'T ON PUB. POL'Y, Feb. 1998, at 1, 1-2, available at <http://www.guttmacher.org/pubs/tgr/01/1/gr010101.pdf>; Sonfield, *supra* note 19, at 1.

<sup>110</sup> ACLU REPORT, *supra* note 75, at 1; CATHOLIC HEALTH CARE, *supra* note 109, at 1-6.

<sup>111</sup> CATHOLIC HEALTH CARE, *supra* note 109, at 1-2. This Note focuses mainly on Catholic health care not only because of its size in the health care market, but also because it places the greatest restrictions on reproductive health care services. See Susan Berke Fogel & Lourdes A. Rivera, *Saving Roe Is Not Enough: When Religion Controls Healthcare*, 31 FORDHAM URB. L.J. 725, 732 (2004) (arguing that limits must be placed on corporate health entities' ability to restrict access to health care services based on religious beliefs). For example, the United Methodist Church recognizes a woman's right to an abortion. Donald H.J. Hermann, *Religious Identity and the Health Care Market: Mergers and Acquisitions Involving Religiously Affiliated Providers*, 34 CREIGHTON L. REV. 927, 959 (2001) (analyzing the health care market's integration of services and challenges faced when secular and religious entities integrate). Also, the Presbyterian Church leaves the moral decision to have an abortion in the hands of the woman, while noting that the decision to have an abortion should be a last resort. *Id.* at 959-60. Additionally, Judaism is likewise not as restrictive as the Catholic Church regarding reproductive health care services. *Id.* at 959. For example, Judaism welcomes the option of in-vitro fertilization. *Id.* Jewish hospitals also do not restrict medical services. Fogel & Rivera, *supra*, at 732.

<sup>112</sup> CATHOLIC HEALTH CARE, *supra* note 109, at 1.

<sup>113</sup> CATHOLIC HEALTH CARE, *supra* note 109, at 2; see U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES §§ 38, 39, 41, 45, 52, 53 (2001) [hereinafter ETHICAL DIRECTIVES].

hospitals in the United States are located in rural areas.<sup>114</sup> Thus, for a woman located in a rural area, the only practically available hospital may be Catholic; as such, her ability to access many reproductive services may be severely limited.<sup>115</sup>

Second, the rapid expansion of managed care has also contributed to the renewed interest in health care provider refusal laws because managed care plans restrict enrollees to a limited pool of health care providers.<sup>116</sup> Traditionally, a patient could seek out alternative providers if his or her primary provider refused to provide certain services; fee-for-service insurance paid for any provider a patient chose.<sup>117</sup> Managed care plans, however, only pay for services performed by certain health care providers.<sup>118</sup> As a result, a patient may be unable to obtain certain services if his or her primary providers refuse to perform them and the patient is unable to afford an alternate provider's services not covered by his or her managed care plan.<sup>119</sup>

Moreover, there has been marked growth in religiously affiliated managed care organizations, which often object to paying for certain reproductive services.<sup>120</sup> For example, as of September 2005, abortion services were largely unavailable under Catholic HMOs.<sup>121</sup> In addition, only approximately one-half of Catholic HMOs cover contraception or sterilization services.<sup>122</sup> This is a significantly lower percentage than the 93% of all HMOs that cover at least one form of contraception, and the 86% that cover sterilization services.<sup>123</sup> As such, it is a significant limitation for the nearly 2.5 million individuals covered by Catholic managed care plans in the United States as of 2000.<sup>124</sup>

Additionally, under the Balanced Budget Act of 1997, Congress now allows Medicaid managed care organizations to refuse to cover certain services based on religious or moral objections.<sup>125</sup> This statute allows a Medicaid managed care organization to refrain from provid-

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<sup>114</sup> CATHOLIC HEALTH CARE, *supra* note 109, at 1.

<sup>115</sup> *See id.* at 1-2.

<sup>116</sup> ACLU REPORT, *supra* note 75, at 2; Gold, *supra* note 109, at 1.

<sup>117</sup> ACLU REPORT, *supra* note 75, at 2.

<sup>118</sup> *Id.*; Gold, *supra* note 109, at 1.

<sup>119</sup> ACLU REPORT, *supra* note 75, at 2; Gold, *supra* note 109, at 1.

<sup>120</sup> ACLU REPORT, *supra* note 75, at 2; Gold, *supra* note 109, at 1.

<sup>121</sup> CATHOLIC HEALTH CARE, *supra* note 109, at 4. An HMO (health maintenance organization) is a type of managed care organization. *See id.*

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> 42 U.S.C. § 1396u-2(b)(3) (2000).

ing, reimbursing for, or providing coverage of a counseling or referral service if the organization objects to the provision of such services on moral or religious grounds.<sup>126</sup>

In addition to the rise in religiously affiliated health care organizations and managed care, the development and increased availability of controversial medical technology has also contributed to the movement towards expanding refusal laws.<sup>127</sup> While most health care provider refusal laws cover abortion, contraception, and sterilization, the range of medical technologies to which health care providers are morally or religiously opposed is broader than those services.<sup>128</sup> In addition to abortion and sterilization services, objectionable technology can include emergency contraception, in vitro fertilization, medical research involving human embryos or fetuses, withdrawal or withholding of life-sustaining treatment, and physician-assisted suicide.<sup>129</sup>

#### D. *Judicial and Legislative Response to Conflict Between Health Care Providers and Patients' Life-Sustaining Treatment Decisions*

Life-sustaining treatment in particular has generated considerable conflict between patients and health care providers who conscientiously object to complying with a patient's decision to forgo or withdraw from such treatment.<sup>130</sup> Life-sustaining treatment refers to any treatment that serves to prolong life without reversing the underlying medical condition.<sup>131</sup> For example, a hospital may keep a patient alive through the use of a respirator or ventilator because she cannot breathe on her own.<sup>132</sup> Additionally, a doctor may give a patient artificial nutrition and hydration because he cannot eat or drink independently.<sup>133</sup>

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<sup>126</sup> *Id.*

<sup>127</sup> ACLU REPORT, *supra* note 75, at 3; Sonfield, *supra* note 19, at 1.

<sup>128</sup> ACLU REPORT, *supra* note 75, at 3; Sonfield, *supra* note 19, at 1.

<sup>129</sup> ACLU REPORT, *supra* note 75, at 3; Sonfield, *supra* note 19, at 1.

<sup>130</sup> See, e.g., Gray v. Romeo, 697 F. Supp. 580, 583 (D.R.I. 1988); Morrison v. Abramovitch, 253 Cal. Rptr. 530, 532 (Ct. App. 1988); Bouvia v. Super. Ct., 225 Cal. Rptr. 297, 304 (Ct. App. 1986); Bartling v. Super. Ct., 209 Cal. Rptr. 220, 222-23 (Ct. App. 1984); Brophy v. New England Sinai Hosp., 497 N.E.2d 626, 632 (Mass. 1986); *In re Jobs*, 529 A.2d 434, 437 (N.J. 1987); *In re Requena*, 517 A.2d 886, 888-89 (N.J. Super. Ct. App. Div. 1986), *aff'd*, 517 A.2d 869 (N.J. Super. Ct. Ch. Div. 1986); Elbaum v. Grace Plaza of Great Neck, Inc., 544 N.Y.S.2d 840, 843 (App. Div. 1989); Delio v. Westchester County Med. Ctr., 516 N.Y.S.2d 677, 680 (App. Div. 1987).

<sup>131</sup> AM. MED. ASS'N, CODE OF MED. ETHICS § 2.20 (2004).

<sup>132</sup> See *id.*

<sup>133</sup> See *id.*

The right to refuse life-sustaining treatment has been recognized by both the judiciary and state legislatures as a broad fundamental right.<sup>134</sup> Courts have recognized this right as emanating from a variety of sources.<sup>135</sup> For example, the right to refuse life-sustaining treatment has been affirmed as a corollary to the common-law right of informed consent.<sup>136</sup> It has also been recognized as rooted in the right to self-determination and personal autonomy.<sup>137</sup> Additionally, some state courts have recognized that the right to refuse life-sustaining treatment can be encompassed within the right to privacy in their respective state constitutions.<sup>138</sup> Lastly, in *Cruzan v. Director, Missouri Department of Health*, the Supreme Court not only noted the various sources to which the right to refuse life-sustaining treatment has been attributed, but also affirmed that the right to refuse life-sustaining medical treatment was a liberty interest encompassed in the Due Process Clause of the Fourteenth Amendment.<sup>139</sup>

States have also recognized the fundamental right to refuse medical treatment in statutory terms.<sup>140</sup> For instance, Alabama law declares that "competent adult persons have the right to control the decisions relating to the rendering of their own medical care, including, without limitation, the decision to have medical procedures . . . withheld, or withdrawn in instances of terminal conditions and permanent unconsciousness."<sup>141</sup> Similarly, Tennessee law states that "every person has the fundamental and inherent right to die naturally with as much dignity as circumstances permit and to accept, refuse,

<sup>134</sup> See, e.g., ALA. CODE § 22-8A-2 (LexisNexis 1997); TENN. CODE ANN. § 32-11-102(a) (2001); W. VA. CODE ANN. § 16-30-2(b)(1) (LexisNexis 2001); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990); *Gray*, 697 F. Supp. at 584-86; *Bouvia*, 225 Cal. Rptr. at 300-04; *Bartling*, 209 Cal. Rptr. at 224-25; *Delio*, 516 N.Y.S.2d at 685-86. Indeed, one commentator has noted that the right to refuse life-sustaining treatment has become a broad "right of virtually any patient to refuse virtually any treatment." David Orentlicher, *The Legalization of Physician-Assisted Suicide: A Very Modest Revolution*, 38 B.C. L. REV. 443, 465 (1997).

<sup>135</sup> See, e.g., *Cruzan*, 497 U.S. at 277-78; *Gray*, 697 F. Supp. at 584-86; *Bouvia*, 225 Cal. Rptr. at 301; *Bartling*, 209 Cal. Rptr. at 224-25; *Delio*, 516 N.Y.S.2d at 686.

<sup>136</sup> See, e.g., *Cruzan*, 497 U.S. at 270; *Bouvia*, 225 Cal. Rptr. at 301 (quoting *Barber v. Super. Ct.*, 195 Cal. Rptr. 484, 489 (Ct. App. 1983)); *Delio*, 516 N.Y.S.2d at 685-86.

<sup>137</sup> See, e.g., *Gray*, 697 F. Supp. at 586; *Brophy*, 497 N.E.2d at 633.

<sup>138</sup> See, e.g., *Bartling*, 209 Cal. Rptr. at 225; *Brophy*, 497 N.E.2d at 633; *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976).

<sup>139</sup> *Cruzan*, 497 U.S. at 277-78.

<sup>140</sup> See, e.g., ALA. CODE § 22-8A-2 (LexisNexis 1997); TENN. CODE ANN. § 32-11-102(a) (2001); W. VA. CODE ANN. § 16-30-2(b)(1) (LexisNexis 2001).

<sup>141</sup> ALA. CODE § 22-8A-2.

withdraw from, or otherwise control decisions relating to the rendering of the person's own medical care."<sup>142</sup>

Accordingly, all states allow a patient (or a surrogate decision maker) to decide to have life-sustaining treatment withdrawn or withheld from the patient, even though such a decision may result in the patient's death.<sup>143</sup> Patients or their surrogates are authorized to make such a decision by virtue of a state's advance directive statute.<sup>144</sup> An advance directive can take the form of a living will, drafted by the patient, which directs a health care provider as to which medical treatment to provide or cease providing.<sup>145</sup> Additionally, a patient may appoint a health care proxy or agent to make a health care decision for him or her in the event the patient is incompetent.<sup>146</sup>

Nevertheless, a patient's decision to withdraw or withhold life-sustaining treatment can raise moral or ethical conflicts for a health care provider.<sup>147</sup> For example, in *Brophy v. New England Sinai Hospital, Inc.*, both the patient's physician and the hospital believed that withdrawing a feeding tube from a patient in a persistent vegetative state would constitute a harmful act that deliberately produced death.<sup>148</sup> Similarly, in *Delio v. Westchester County Medical Center*, the hospital objected to withdrawing a feeding tube from a patient because it be-

<sup>142</sup> TENN. CODE ANN. § 32-11-102(a). Additionally, the West Virginia legislature states that "[c]ommon law tradition and the medical profession in general have traditionally recognized the right of a capable adult to accept or reject medical or surgical intervention affecting one's own medical condition." W. VA. CODE ANN. § 16-30-2(b)(1).

<sup>143</sup> See, e.g., ALA. CODE § 22-8A-4 (LexisNexis 1997 & Supp. 2005); CAL. PROB. CODE §§ 4670, 4671(a) (West Supp. 2006); CONN. GEN. STAT. ANN. §§ 19a-575, 576 (West 2003); KY. REV. STAT. ANN. § 311.623(1) (LexisNexis 2001 & Supp. 2005); MASS. GEN. LAWS ANN. ch. 201D, § 2 (West 2004); S.D. CODIFIED LAWS § 34-12D-2 (2004); TENN. CODE ANN. § 32-11-104(a) (2001); W. VA. CODE ANN. § 16-30-4 (LexisNexis 2001 & Supp. 2005).

<sup>144</sup> See, e.g., ALA. CODE § 22-8A-4; CAL. PROB. CODE §§ 4670, 4671(a); CONN. GEN. STAT. ANN. §§ 19a-575, 576; KY. REV. STAT. ANN. § 311.623; MASS. GEN. LAWS ANN. ch. 201D, § 2; S.D. CODIFIED LAWS § 34-12D-2; TENN. CODE ANN. § 32-11-104(a); W. VA. CODE ANN. § 16-30-4.

<sup>145</sup> See, e.g., ALA. CODE § 22-8A-4(a); CONN. GEN. STAT. ANN. § 19a-575; KY. REV. STAT. ANN. § 311.623(1)(a), (b); S.D. CODIFIED LAWS § 34-12D-2; TENN. CODE ANN. § 32-11-104(a).

<sup>146</sup> See, e.g., ALA. CODE § 22-8A-4(b); CONN. GEN. STAT. ANN. § 19a-576(a); KY. REV. STAT. ANN. § 311.623(1)(c); MASS. GEN. LAWS ANN. ch. 201D, § 2; W. VA. CODE ANN. § 16-30-4.

<sup>147</sup> See, e.g., *Gray*, 697 F. Supp. at 583; *Morrison*, 253 Cal. Rptr. at 532; *Bouvia*, 225 Cal. Rptr. at 304; *Brophy*, 497 N.E.2d at 632; *Jobes*, 529 A.2d at 437; *Elbaum*, 544 N.Y.S.2d at 843; *Delio*, 516 N.Y.S.2d at 680.

<sup>148</sup> 497 N.E.2d at 632.

lieved that doing so would be contrary to its moral and ethical standards and its mission of preserving life.<sup>149</sup>

Withdrawing from life-sustaining treatment may cause religious concerns for a health care provider as well.<sup>150</sup> For instance, the Ethical and Religious Directives for Catholic Health Care Services states that there should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.<sup>151</sup> Thus, a patient may wish to withdraw or withhold life-sustaining treatment, but if the health care provider believes the benefits of treatment outweigh the burdens to the patient, the health care provider may refuse to do so on religious grounds.<sup>152</sup>

### 1. Judicial Response to the Conflict Between a Patient's Request to Refuse Life-Sustaining Treatment and a Health Care Provider's Conscientious Objection

Several court decisions have addressed the situation where a health care provider conscientiously objects to a patient's request to withdraw or withhold life-sustaining treatment.<sup>153</sup> Some courts attempted to protect the patient's right to refuse treatment while still accommodating the health care provider's conscientious objection by requiring that the patient be transferred to another health care provider willing to carry out the patient's wishes to withdraw life-sustaining treatment.<sup>154</sup>

For example, in *Brophy*, the wife of a patient in a persistent vegetative state wished to have life-sustaining nutrition and hydration withdrawn from the patient.<sup>155</sup> The patient's physicians as well as the

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<sup>149</sup> 516 N.Y.S.2d at 680.

<sup>150</sup> See e.g., *Bartling*, 209 Cal. Rptr. at 223; *Requena*, 517 A.2d at 887–89; ETHICAL DIRECTIVES, *supra* note 113, §§ 56–59.

<sup>151</sup> ETHICAL DIRECTIVES, *supra* note 113, § 58.

<sup>152</sup> See *id.*

<sup>153</sup> See, e.g., *Gray*, 697 F. Supp. at 583; *Morrison*, 253 Cal. Rptr. at 532; *Bouvia*, 225 Cal. Rptr. at 298; *Bartling*, 209 Cal. Rptr. at 221; *Brophy*, 497 N.E.2d at 627; *Jobes*, 529 A.2d at 437; *Requena*, 517 A.2d at 887; *Elbaum*, 544 N.Y.S.2d at 842; *Delio*, 516 N.Y.S.2d at 680.

<sup>154</sup> See *Morrison*, 253 Cal. Rptr. at 534–35; *Brophy*, 497 N.E.2d at 639–40.

<sup>155</sup> 497 N.E.2d at 631–32. A person in a persistent vegetative state is unaware of his or her surroundings and lacks cognitive abilities, but may still exhibit non-cognitive functions, such as breathing, circulation, and spontaneous movements. See Nat'l Institute of Neurological Disorders and Stroke, Nat'l Inst. of Health, NINDS Coma and Persistent Vegetative State Information Page, <http://www.ninds.nih.gov/disorders/coma/coma.htm> (last visited July 29, 2006). As the political firestorm surrounding the removal of Terri

hospital refused to withdraw the feeding tube, believing that doing so would constitute a harmful act which would deliberately produce death.<sup>156</sup> The hospital, however, was not opposed to transferring the patient to another facility willing to remove the feeding tube.<sup>157</sup> The Supreme Judicial Court of Massachusetts reasoned that so long as the patient's right to self-determination was not denied and the patient's wishes were fulfilled at another facility, it was possible to preserve the ethical integrity of the hospital and its staff.<sup>158</sup>

More than one court has gone further to protect the patient's right to withdraw life-sustaining treatment over the health care provider's objections by explicitly requiring the health care provider to carry out the patient's wishes if a transfer was not possible.<sup>159</sup> For example, in *Gray v. Romeo*, the family of a patient in a persistent vegetative state requested that the patient be removed from artificial nutrition and hydration.<sup>160</sup> The hospital refused to comply with the request because, as an institution, it was opposed to withdrawing nutrition and hydration.<sup>161</sup> It equated the withdrawal of nutrition and hydration with euthanasia.<sup>162</sup> The U.S. District Court for the District of Rhode Island, however, while noting that it would be unsettling to the health care professionals who opposed withdrawing the feeding tube, held that the hospital had no choice but to acknowledge the patient's right of self-determination.<sup>163</sup> As a result, if the patient could not be promptly transferred to a health care facility willing to respect the patient's wishes, the hospital was obligated to comply with the patient's requests.<sup>164</sup>

Furthermore, at least one court has held that, even though transferring the patient to another facility was possible, the facility had to comply with the patient's wishes to refuse artificial feeding.<sup>165</sup> In *In re Requena*, a woman dying of amyotrophic lateral sclerosis, which rendered her unable to ingest food orally, refused to accept artificial nu-

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Schiavo's feeding tube demonstrated, patients may spend decades in such a state and may never recover. See Abby Goodnough, *Schiavo Autopsy Says Brain, Withered, Was Untreatable*, N.Y. TIMES, June 16, 2005, at A1.

<sup>156</sup> *Brophy*, 497 N.E.2d at 632.

<sup>157</sup> *Id.*

<sup>158</sup> *Id.* at 639.

<sup>159</sup> See *Gray*, 697 F. Supp. at 591; *Jobes*, 529 A.2d at 450; *Elbaum*, 544 N.Y.S.2d at 848.

<sup>160</sup> 697 F. Supp. at 583.

<sup>161</sup> *Id.*

<sup>162</sup> *Id.*

<sup>163</sup> *Id.* at 591.

<sup>164</sup> *Id.*

<sup>165</sup> See *Requena*, 517 A.2d at 889.

trition and hydration.<sup>166</sup> The hospital had a policy against withholding or withdrawing food or fluids from patients and refused to comply with the patient's wishes.<sup>167</sup> It was, however, willing to assist in transferring the patient to another institution which would carry out the patient's request.<sup>168</sup> Although transferring the patient was both medically and practically feasible, the Superior Court of New Jersey ordered the hospital to honor the patient's request.<sup>169</sup> The court stated that it would be too emotionally and psychologically upsetting to force the patient to leave the hospital.<sup>170</sup>

In deciding whether to require the facility to comply with the patient's wishes, courts also sometimes consider whether the patient and his or her family had notice of the facility's official policy regarding life-sustaining treatment prior to or upon admission to the facility.<sup>171</sup> Some courts have reasoned that, without prior notice of a health care provider's policy regarding life-sustaining treatment, a patient is entitled to presume that his or her right to refuse treatment would not be hindered.<sup>172</sup>

For instance, in *In re Jobes*, a nursing home refused on moral grounds to comply with a patient's family's request to remove the patient from life-sustaining artificial nutrition and hydration.<sup>173</sup> The nursing home, however, did not inform the patient's family of its policy regarding artificial feeding until the patient's family requested that the feeding tube be removed.<sup>174</sup> Nor was there any indication that the nursing home's policy against removing artificial nutrition and hydration was ever formalized.<sup>175</sup> The Supreme Court of New Jersey noted that the patient's family had no notice that they were surrendering the right to choose among medical alternatives when they placed the patient in the nursing home.<sup>176</sup> As a result, the court held that the

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<sup>166</sup> *Id.* at 887–88.

<sup>167</sup> *Id.* at 888–89.

<sup>168</sup> *Id.* at 889.

<sup>169</sup> *Id.* at 890.

<sup>170</sup> *Requena*, 517 A.2d at 892–93.

<sup>171</sup> See *Gray*, 697 F. Supp. at 590–91; *Jobes*, 529 A.2d at 450; *Requena*, 517 A.2d at 870; *Elbaum*, 544 N.Y.S.2d at 847–48.

<sup>172</sup> See *Gray*, 697 F. Supp. at 590–91; *Jobes*, 529 A.2d at 450; *Requena*, 517 A.2d at 870; *Elbaum*, 544 N.Y.S.2d at 847–48.

<sup>173</sup> 529 A.2d at 437.

<sup>174</sup> *Id.* at 450.

<sup>175</sup> *Id.*

<sup>176</sup> *Id.*



family was entitled to rely on the nursing home's apparent willingness to defer to the family's choice of medical treatment for the patient.<sup>177</sup>

## 2. Legislative Response to the Conflict Between a Patient's Wish to Refuse Life-Sustaining Treatment and a Health Care Provider's Conscientious Objection

Most states allow a health care provider to refuse to comply with a patient's life-sustaining treatment decision as contained within the patient's advance directive if the health care provider opposes the treatment decision the patient has made.<sup>178</sup> Refusing to comply with the patient's wishes, however, usually imposes additional duties on the health care provider.<sup>179</sup> These additional duties ensure that a patient is not prevented from exercising his or her right to refuse medical treatment, while still accommodating the health care provider's religious, moral, or ethical integrity.<sup>180</sup>

For example, in most states, the physician or facility that objects to honoring the patient's decision must aid the patient and his or her family in transferring the patient to a physician or facility that will carry out the decision.<sup>181</sup> Additionally, a few states address the situation that arises if a transfer cannot be arranged.<sup>182</sup> For instance, New York and Massachusetts impose an additional duty: if a transfer cannot be arranged, the health care provider must either seek judicial

<sup>177</sup> *Id.*

<sup>178</sup> See, e.g., ALA. CODE § 22-8A-8(b) (LexisNexis 1997); CAL. PROB. CODE § 4736 (West Supp. 2005); CONN. GEN. STAT. ANN. § 19a-580a (West 2003); KY. REV. STAT. ANN. § 311.633(3) (LexisNexis 2001); S.D. CODIFIED LAWS § 34-12D-11 (2004); TENN. CODE ANN. § 32-11-108(a) (2001).

<sup>179</sup> See, e.g., ALA. CODE § 22-8A-8(a); CAL. PROB. CODE § 4736(a), (b); COLO. REV. STAT. § 15-14-507(1), (2) (2004); CONN. GEN. STAT. ANN. § 19a-580a; FLA. STAT. ANN. § 765.1105 (West 2005); KY. REV. STAT. ANN. § 311.633(2); N.J. STAT. ANN. § 26:2H-65 (West 1996); N.Y. PUB. HEALTH LAW § 2984(3), (4) (McKinney 2002); S.D. CODIFIED LAWS § 34-12D-11; TENN. CODE ANN. § 32-11-108(a).

<sup>180</sup> See ALA. CODE § 22-8A-8(a) (LexisNexis 1997); COLO. REV. STAT. § 15-14-507(1), (2); CAL. PROB. CODE § 4736(a), (b); CONN. GEN. STAT. ANN. § 19a-580a; FLA. STAT. ANN. § 765.1105; KY. REV. STAT. ANN. § 311.633(2); N.J. STAT. ANN. § 26:2H-65; N.Y. PUB. HEALTH LAW § 2984(3), (4); S.D. CODIFIED LAWS § 34-12D-11; TENN. CODE ANN. § 32-11-108(a).

<sup>181</sup> See, e.g., ALA. CODE § 22-8A-8(a); CAL. PROB. CODE § 4736(b); CONN. GEN. STAT. ANN. § 19a-580a; FLA. STAT. ANN. § 765.1105; KY. REV. STAT. ANN. § 311.633(2); S.D. CODIFIED LAWS § 34-12D-11; TENN. CODE ANN. § 32-11-108(a).

<sup>182</sup> See, e.g., FLA. STAT. ANN. § 765.1105(b); IND. CODE ANN. § 16-36-4-13 (LexisNexis 1993); KAN. STAT. ANN. § 65-28,107(a) (2002); MASS. GEN. LAWS ANN. ch. 201D, § 14 (West 2004); N.Y. PUB. HEALTH LAW § 2984(3)(b); R.I. GEN. LAWS § 23-4.11-9(a) (2001); UTAH CODE ANN. § 75-2-1112(3) (1993).

relief or honor the patient's or health care proxy's decision.<sup>183</sup> By contrast, Indiana laws declare that if an attending physician cannot find another physician willing to carry out the patient's wishes to withdraw or withhold life-sustaining treatment, the attending physician may refuse to comply with the patient's wishes.<sup>184</sup> Moreover, in Kansas, Rhode Island, and Utah, failure to effect the transfer of the patient to another facility constitutes unprofessional conduct.<sup>185</sup>

Some states also require a health care facility to give notice to the patient and his or her family, prior to or upon admission, of the facility's policy of refusing to withdraw life-sustaining treatment.<sup>186</sup> In fact, federal regulation has also imposed a notice requirement on health care facilities that receive Medicare and Medicaid funding.<sup>187</sup> In order to refuse to comply with a patient's advance directive for reasons of conscience, a health care facility must have clear and precisely written policies explaining the facility's limitations.<sup>188</sup> The statement, at a minimum, should (1) clarify differences between institution-wide conscience objections and those that may be raised by individual physicians, (2) identify the state legal authority permitting such objections, and (3) describe the medical conditions that would be affected by these objections.<sup>189</sup> This information must be given when an individual is admitted to the facility.<sup>190</sup>

### III. PHARMACIST REFUSAL LAWS

Refusal clauses have expanded not only to cover health care services other than abortion and contraception, such as life-sustaining treatment, but also to include health care providers other than doctors and nurses who were not initially included in refusal laws.<sup>191</sup> Specifically, pharmacists have asserted their right to conscientiously object.<sup>192</sup>

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<sup>183</sup> MASS. GEN. LAWS ANN. ch. 201D, § 14; N.Y. PUB. HEALTH LAW § 2984(3)(b).

<sup>184</sup> IND. CODE ANN. § 16-36-4-13.

<sup>185</sup> KAN. STAT. ANN. § 65-28,107(a); R.I. GEN. LAWS §23-4.11-9(a); UTAH CODE ANN. § 75-2-1112(3).

<sup>186</sup> See, e.g., COLO. REV. STAT. § 15-14-507(1) (2004); FLA. STAT. ANN. § 765.1105(1)(b) (West 2005); N.J. STAT. ANN. § 26:2H-65(b) (West 1996); N.Y. PUB. HEALTH LAW § 2984(3)(a) (McKinney 2002).

<sup>187</sup> 42 C.F.R. § 489.102(a)(1) (2004).

<sup>188</sup> *Id.* § 489.102(a)(1)(ii).

<sup>189</sup> *Id.*

<sup>190</sup> *Id.* § 489.102(b)(1), (2).

<sup>191</sup> Sonfield, *supra* note 19, at 1.

<sup>192</sup> See Pharmacists for Life, *supra* note 20.

Some have criticized pharmacists' motivations in asserting this right, claiming that it is an organized campaign by religious conservatives to encroach on patients' rights to access controversial medical services.<sup>193</sup> On the other hand, pharmacists, like physicians, play an important and unique role in the health care system.<sup>194</sup> Among other tasks, pharmacists have the role of reviewing the appropriateness of a patient's drug therapy, intervening when there is a potential problem, and instructing patients on how to use medications safely and effectively.<sup>195</sup> It follows that, like physicians and nurses, pharmacists should not be forced to participate in procedures to which they have religious, moral, or ethical objections.<sup>196</sup>

#### A. *Emergency Contraception's Role in the Push for Pharmacist Refusal Laws*

Pharmacists' interest in invoking refusal laws has arisen largely in response to the availability of emergency contraception. In 1998 and 1999, two pharmaceutical products, Preven and Plan B, became available as products packaged and marketed specifically for use as emergency contraception.<sup>197</sup> The arrival of these drugs thus sparked considerable controversy among pharmacists who objected to prescribing emergency contraception due to religious, ethical, or moral beliefs.<sup>198</sup>

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<sup>193</sup> See Sonfield, *supra* note 19, at 1; Paulson, *supra* note 5, at 1; Stein, *supra* note 5, at A1.

<sup>194</sup> *Freedom of Conscience for Small Pharmacies: Hearing Before the H. Small Bus. Comm.*, 109th Cong. app. at 62 (2005), available at [http://frwebgate.access.gpo.gov/cgi-bin/ufseft.cgi?IPaddress=162.140.64.128&filename=22612.pdf&directory=/diskb/wais/data/109\\_house\\_hearings](http://frwebgate.access.gpo.gov/cgi-bin/ufseft.cgi?IPaddress=162.140.64.128&filename=22612.pdf&directory=/diskb/wais/data/109_house_hearings) [hereinafter *Hearing*] (statement of Linda Garrelts MacLean, RPh, CDE, member, American Pharmacists Association); William L. Allen & David B. Brushwood, *Pharmaceutically Assisted Death and the Pharmacist's Right of Conscience*, 5 J. PHARMACY & L. 1, 2-6 (1996).

<sup>195</sup> Allen & Brushwood, *supra* note 194, at 2-6.

<sup>196</sup> *Hearing*, *supra* note 194, app. at 62.

<sup>197</sup> AMERICAN PHARMACEUTICAL ASS'N, APHA SPECIAL REPORT: EMERGENCY CONTRACEPTION: THE PHARMACIST'S ROLE 1, 3 (2000), available at [http://www.pharmacists.com/pdf/emerg\\_contra.pdf](http://www.pharmacists.com/pdf/emerg_contra.pdf) [hereinafter APHA REPORT]. Emergency contraception consists of the same hormones as oral contraceptives taken on a daily basis, but are taken in a concentrated pill form shortly after unprotected sexual intercourse. Heather Boonstra, *Emergency Contraception: Increasing Public Awareness*, GUTTMACHER REP'T ON PUB. POL'Y, Oct. 2002, at 1, 1 available at <http://www.guttmacher.org/pubs/tgr/05/4/gr050403.pdf>. Like daily oral contraceptives, they have the ability to prevent pregnancy through various mechanisms, including interfering with ovulation, fertilization, the transport of the fertilized egg to the uterus, or implantation of the blastocyst into the uterus. APHA REPORT, *supra*, at 2.

<sup>198</sup> Susan A. Cohen, *Objections, Confusion Among Pharmacists Threaten Access to Emergency Contraception*, GUTTMACHER REP'T ON PUB. POL'Y, June 1999, at 1, 1, available at <http://www.guttmacher.org/pubs/tgr/02/3/gr020301.pdf>; Stein, *supra* note 5, at A1.

In particular, emergency contraception raised objections from pro-life pharmacists because they believed that they would be participating in an abortion procedure by dispensing the drug.<sup>199</sup>

The American Pharmaceutical Association, however, has stated that emergency contraception does not cause an abortion.<sup>200</sup> According to this view, implantation of the fertilized egg establishes a pregnancy.<sup>201</sup> Unlike RU-486, which acts after implantation of the egg into the uterus, emergency contraception acts before implantation of the fertilized egg into the uterus, and thus cannot disrupt an established pregnancy, which is measured by whether the fertilized egg has already been implanted.<sup>202</sup> It is therefore not an abortifacient.<sup>203</sup>

Pro-life groups, however, contend that emergency contraception does cause an abortion.<sup>204</sup> For example, Pharmacists for Life, a pro-life association of pharmacists, believes that pregnancy begins with the fertilization of an egg rather than at the time of implantation.<sup>205</sup> Because emergency contraception may prevent pregnancy by preventing the fertilized egg from implanting, this group believes that emergency contraception terminates an established pregnancy by acting after fertilization of the egg has occurred.<sup>206</sup> Pharmacists for Life and other groups also believe that daily oral contraceptives can also act as chemical abortifacients because those medications can interfere with processes that occur after fertilization of the egg.<sup>207</sup>

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<sup>199</sup> See Cohen, *supra* note 198, at 1; Bergquist, *supra* note 26, at 1077-78.

<sup>200</sup> APHA REPORT, *supra* note 197, at 3.

<sup>201</sup> See *id.*

<sup>202</sup> See APHA REPORT, *supra* note 197, at 3-4; Cohen, *supra* note 198, at 1-2. Some pharmacists' objections to dispensing emergency contraception may actually have grown out of confusion in the media equating emergency contraception and RU-486. See APHA REPORT, *supra* note 197, at 3-4; Cohen, *supra* note 198, at 1-2. For a discussion of the FDA's approval of RU-486, which is otherwise known as mifepristone, see generally Lars Noah, *A Miscarriage in the Drug Approval Process? Mifepristone Embroils the FDA in Abortion Politics*, 366 WAKE FOREST L. REV. 571 (2001).

<sup>203</sup> See APHA REPORT, *supra* note 197, at 3.

<sup>204</sup> See Pharmacists for Life Int'l, *The Pill—How It Works and Fails*, [http://www.pfli.org/faq\\_oc.html](http://www.pfli.org/faq_oc.html) (last visited Mar. 24, 2006) [hereinafter *The Pill*].

<sup>205</sup> *Id.*

<sup>206</sup> *Id.*

<sup>207</sup> See APHA REPORT, *supra* note 197, at 3, 12; *The Pill*, *supra* note 204.

## B. Pharmacist Refusal Laws

### 1. Broad Pharmacist Refusal Laws

The controversy concerning emergency contraception provided momentum for expanding health care provider refusal laws to include pharmacists.<sup>208</sup> For example, South Dakota law allows a pharmacist to refuse to dispense medication that would cause an abortion or destroy an unborn child.<sup>209</sup> The law defines an unborn child as an organism existing from fertilization to live birth.<sup>210</sup> Under this definition, any type of oral contraceptive, not merely emergency contraception, may qualify as an abortifacient because these medications may interfere with processes that occur after fertilization.<sup>211</sup>

Arkansas has also recognized that pharmacists may object to filling prescriptions for any type of contraceptive.<sup>212</sup> Its pharmacist refusal clause states that nothing prohibits a pharmacist from refusing to furnish any contraceptive procedures, supplies, or information.<sup>213</sup>

Two states enacted even broader legislation, allowing for pharmacists' refusal to dispense any medication to which they were morally opposed.<sup>214</sup> For example, Georgia's State Board of Pharmacy's Code of Professional Conduct simply declares that a pharmacist who, for moral reasons, refuses to fill a prescription does not violate professional conduct standards.<sup>215</sup> Additionally, Mississippi's broad refusal clause grants all health care providers, including pharmacists, the right to refuse to participate in any health care service that violates the health care provider's conscience.<sup>216</sup>

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<sup>208</sup> See Cohen, *supra* note 198, at 1; Sonfield, *supra* note 17, at 7; Stein, *supra* note 5, at A1. See generally Donald W. Herbe, Note, *The Right to Refuse: A Call for Adequate Protection of a Pharmacist's Right to Refuse Facilitation of Abortion and Emergency Contraception*, 17 J.L. & HEALTH 77 (2002-03) (advocating for expanding refusal laws to include pharmacists to accommodate their conscientious objections in the context of abortion and emergency contraception).

<sup>209</sup> S.D. CODIFIED LAWS § 36-11-70 (2004).

<sup>210</sup> *Id.* § 22-1-2(50A) (2004).

<sup>211</sup> See APHA REPORT, *supra* note 197, at 3, 12.

<sup>212</sup> See ARK. CODE ANN. § 20-16-304(4) (West 2005).

<sup>213</sup> *Id.*

<sup>214</sup> See MISS. CODE ANN. §§ 41-107-3(a), (b), -5(1) (2005); GA. COMP. R. & REGS. 480-5-.03(n) (2001).

<sup>215</sup> GA. COMP. R. & REGS. 480-5-.03(n).

<sup>216</sup> MISS. CODE ANN. §§ 41-107-3(a), (b), -5(1).

## 2. Restrictive Pharmacist Refusal Laws

By contrast, Illinois has restricted a pharmacist's right to refuse to dispense contraception.<sup>217</sup> Under Illinois law, if a contraceptive is in stock at a pharmacy, the pharmacy must dispense the contraceptive to a patient without delay.<sup>218</sup> If the contraceptive is not in stock, the pharmacy must provide a suitable alternative, order the drug, or transfer the prescription to a local pharmacy of the patient's choice.<sup>219</sup> This law does not mention an individual pharmacist's right to object ethically, morally, or religiously to dispensing contraceptives.<sup>220</sup> Thus, in a situation where a pharmacy stocks contraceptive medications, but the only pharmacist on duty has a religious, moral, or ethical opposition to dispensing contraceptives, the pharmacist may have no choice but to dispense the prescription.<sup>221</sup>

Moreover, Illinois's Health Care Right of Conscience Act most likely does not protect objecting pharmacists.<sup>222</sup> The statute offers broad protection from liability for health care personnel who refuse to perform or assist in any way in any health care service that is contrary to their conscience.<sup>223</sup> It appears, however, that pharmacists are not considered "health care personnel" for purposes of the statute.<sup>224</sup> In fact, Republican State Senator Dan Rutherford said that attempts to include pharmacists in the definition of "health care personnel" have failed.<sup>225</sup>

## 3. A More Balanced Approach Taken by the American Pharmacists Association and California

Rather than choosing to give broad rights to either pharmacists or patients, the American Pharmacists Association (the "APhA") responded to Illinois's law by taking a more balanced position on a pharmacist's right to refuse to dispense contraceptives based on

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<sup>217</sup> ILL. ADMIN. CODE tit. 68, § 1330.91 (2005); Paulson, *supra* note 5, at 1.

<sup>218</sup> ILL. ADMIN. CODE tit. 68, § 1330.91.

<sup>219</sup> *Id.*

<sup>220</sup> *See id.*

<sup>221</sup> *See id.*

<sup>222</sup> *See* 745 ILL. COMP. STAT. ANN. 70/4 (2002).

<sup>223</sup> *See id.*

<sup>224</sup> *See id.* 70/3(c) (defining "health care personnel" as "any nurse, nurses' aide, medical school student, professional, paraprofessional or any other person who furnishes, or assists in the furnishing of, health care services"); *see also* Chase, *supra* note 10, at 3 (noting the lack of statutory protection for conscientiously objecting pharmacists).

<sup>225</sup> *See* 745 ILL. COMP. STAT. ANN. 70/3(c); Chase, *supra* note 10, at 3.

moral objections.<sup>226</sup> The APhA recognizes a pharmacist's right to refuse, but contends that there should also be a system in place to ensure that the patient's health care needs are served.<sup>227</sup> Among other things, the APhA suggests that a pharmacy should be staffed such that if an objecting pharmacist is on call, another pharmacist in the same pharmacy could dispense the medication.<sup>228</sup> If that is not possible, the pharmacy could transfer the prescription to a different pharmacy that will dispense the medication.<sup>229</sup> Additionally, the APhA suggests that prescribers direct patients to pharmacies that they know will dispense the medication.<sup>230</sup>

Similarly, California allows a pharmacist to refuse to dispense prescriptions to which he or she is ethically, morally, or religiously opposed.<sup>231</sup> California law requires the pharmacist and pharmacy, however, to ensure that the patient is able to receive her prescription in a timely manner.<sup>232</sup> To refuse to dispense a prescription, the pharmacist must have previously notified his or her employer in writing of the drugs that he or she objects to dispensing.<sup>233</sup> The pharmacist will then only be permitted to refuse if the employer can reasonably accommodate this refusal without creating undue hardship on the employer.<sup>234</sup> The employer must also establish means to ensure that the patient has

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<sup>226</sup> *Hearing*, *supra* note 194, app. at 61-64.

<sup>227</sup> *Id.* app. at 62.

<sup>228</sup> *Id.*

<sup>229</sup> *Id.*

<sup>230</sup> *Id.*

<sup>231</sup> CAL. BUS. & PROF. CODE § 733(b)(3) (West Supp. 2006).

<sup>232</sup> *Id.*

<sup>233</sup> *Id.*

<sup>234</sup> *Id.* (noting that "undue hardship" shall have the same meaning as applied to "undue hardship" pursuant to subdivision (l) of section 12940 of California's Government Code). Section 12940 cross-references to the definition of "undue hardship" in Section 12926. CAL. GOV'T CODE § 12940 (West 2005). Subsection (s) of section 12926 defines "undue hardship" as an action requiring significant difficulty or expense, when considered in light of several factors, including (1) the nature and cost of the accommodation needed; (2) the overall financial resources of the facilities involved in the provision of the reasonable accommodations, the number of persons employed at the facility, and the effect on expenses and resources or the impact otherwise of these accommodations upon the operation of the facility; (3) the overall financial resources of the covered entity, the overall size of the business of a covered entity with respect to the number of employees, and the number, type, and location of its facilities; (4) the type of operations, including the composition, structure, and functions of the workforce of the entity; and (5) the geographic separateness, administrative, or fiscal relationship of the facility or facilities. CAL. GOV'T CODE § 12926(s) (West 2005).

timely access to the drug, despite the pharmacist's refusal to dispense it.<sup>235</sup>

#### IV. LIFE-SUSTAINING TREATMENT LAW AS A MODEL FOR BALANCING A PHARMACIST'S RIGHT TO CONSCIENTIOUSLY OBJECT WITH A WOMAN'S RIGHT TO OBTAIN CONTRACEPTIVES

##### A. *A Failure to Balance Competing Interests in Current Pharmacist Legislation*

A few states have explicitly addressed the issue of a pharmacist's right to refuse to dispense contraceptives based on religious, moral, or ethical views.<sup>236</sup> Of those states, Georgia, Mississippi, South Dakota, and Arkansas fail to protect adequately a woman's fundamental right to use contraceptives.<sup>237</sup> In these states, a pharmacist may flatly refuse to dispense a prescription for a contraceptive and the pharmacist has no obligation to assist the woman in filling her prescription.<sup>238</sup> Moreover, there is no requirement that pharmacists or their employers give notice to women that their prescriptions may not be filled because of the pharmacists' religious, moral, or ethical beliefs.<sup>239</sup> In sum, the legislation leaves women with no recourse for filling their contraceptive prescriptions in a timely manner.<sup>240</sup>

The inability to fill contraceptive prescriptions in a timely manner significantly hinders a woman's fundamental right to choose to access and use contraceptives.<sup>241</sup> Timely access to birth control pre-

<sup>235</sup> CAL. BUS. & PROF. CODE § 733(b)(3).

<sup>236</sup> See ARK. CODE ANN. § 20-16-304(4) (West 2005); CAL. BUS. & PROF. CODE § 733(b)(3) (West Supp. 2006); MISS. CODE ANN. §§ 41-107-3(a), (b), -5(1) (2005); S.D. CODIFIED LAWS § 36-11-70 (2004); GA. COMP. R. & REGS. 480-5-.03(n) (2001); ILL. ADMIN. CODE tit. 68, § 1330.91 (2005).

<sup>237</sup> See ARK. CODE ANN. § 20-16-304(4); MISS. CODE ANN. §§ 41-107-3(a), (b), -5(1); S.D. CODIFIED LAWS § 36-11-70; *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992); *Carey v. Population Servs. Int'l Inc.*, 431 U.S. 678, 685 (1977); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965); GA. COMP. R. & REGS. 480-5-.03(n).

<sup>238</sup> See ARK. CODE ANN. § 20-16-304(4); MISS. CODE ANN. §§ 41-107-3(a), (b), -5(1); S.D. CODIFIED LAWS § 36-11-70; GA. COMP. R. & REGS. 480-5-.03(n).

<sup>239</sup> See ARK. CODE ANN. § 20-16-304(4); MISS. CODE ANN. §§ 41-107-3(a), (b), -5(1); S.D. CODIFIED LAWS § 36-11-70; GA. COMP. R. & REGS. 480-5-.03(n).

<sup>240</sup> See ARK. CODE ANN. § 20-16-304(4); MISS. CODE ANN. §§ 41-107-3(a), (b), -5(1); S.D. CODIFIED LAWS § 36-11-70; GA. COMP. R. & REGS. 480-5-.03(n).

<sup>241</sup> See *Casey*, 505 U.S. at 851; *Carey*, 431 U.S. at 685; *Eisenstadt*, 405 U.S. at 453-54; *Griswold*, 381 U.S. at 485; APhA REPORT, *supra* note 197, at 4; Julie Cantor & Ken Baum, *The Limits of Conscientious Objection—May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?*, 351 NEW ENG. J. MED. 2008, 2010 (2004).



scriptions is essential to women who use contraceptives because the effectiveness of many contraceptives depends on the ability to take them within a certain time frame.<sup>242</sup> Timeliness is an especially critical issue for women seeking to fill a prescription for emergency contraception; the medication is most effective at preventing pregnancy if taken within seventy-two hours or fewer of unprotected sexual intercourse.<sup>243</sup>

If a woman experiences a delay in receiving emergency contraception because she cannot find a pharmacist who will dispense it, the time within which she must take the medication may pass, dramatically increasing the chance of pregnancy.<sup>244</sup> For a woman who lives in an urban area with a multitude of pharmacies within a small radius, or a woman with the means to travel to another pharmacy, this may be no more than an inconvenience.<sup>245</sup> For low-income women and women who live in rural areas, however, such a law places a significant obstacle in the way of exercising the fundamental right to access and use contraceptives.<sup>246</sup> If the fundamental right to use and access contraceptives is to have any meaning, all women who choose to exercise their right need to be able to fill their contraceptive prescriptions in a timely manner, so that their choice to exercise this right will not be rendered ineffective or moot by the passage of time.<sup>247</sup>

Illinois, on the other hand, has failed to protect adequately the pharmacist's right to conscientiously object to dispensing such prescriptions by requiring a pharmacy to dispense a contraceptive, without delay, if it is in stock.<sup>248</sup> A pharmacist who conscientiously objects to dispensing contraceptives may be forced to dispense a contraceptive if he or she is employed by a pharmacy that stocks contraceptives.<sup>249</sup> This could happen, for example, if the pharmacy has contraceptives in stock and the pharmacist is the only pharmacist on duty at

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<sup>242</sup> See APHA REPORT, *supra* note 197, at 4; Cantor & Baum, *supra* note 241, at 2010.

<sup>243</sup> See APHA REPORT, *supra* note 197, at 4; Cantor & Baum, *supra* note 241, at 2010.

<sup>244</sup> See APHA REPORT, *supra* note 197, at 4; Cantor & Baum, *supra* note 241, at 2010.

<sup>245</sup> See *Casey*, 505 U.S. at 851; *Carey*, 431 U.S. at 685; *Eisenstadt*, 405 U.S. at 453; *Griswold*, 381 U.S. at 485; Cantor & Baum, *supra* note 241, at 2010; Cohen, *supra* note 198, at 2.

<sup>246</sup> See *Casey*, 505 U.S. at 851; *Carey*, 431 U.S. at 685; *Eisenstadt*, 405 U.S. at 453; *Griswold*, 381 U.S. at 485; Cantor & Baum, *supra* note 241, at 2010; Cohen, *supra* note 198, at 2.

<sup>247</sup> See *Casey*, 505 U.S. at 851; *Carey*, 431 U.S. at 685; *Eisenstadt*, 405 U.S. at 453-54; *Griswold*, 381 U.S. at 485-86; Cantor & Baum, *supra* note 241, at 2010; Cohen, *supra* note 198, at 2.

<sup>248</sup> See ILL. ADMIN. CODE tit. 68, § 1330.91 (2005).

<sup>249</sup> See *id.*

a particular time, or if there is no other willing pharmacist working at the same time to fill the prescription.<sup>250</sup>

B. *Model for Balancing Competing Interests in Pharmacist  
Refusal Clause Legislation*

I. Fundamental Rights May Present Moral Conflict

Life-sustaining treatment court decisions and legislation provide a model for pharmacist refusal clause legislation because the use of contraceptives implicates a fundamental liberty interest in the same way that refusing life-sustaining treatment does.<sup>251</sup> The Supreme Court has recognized that the Due Process Clause of the Fourteenth Amendment protects both the right to use and access contraceptives and the right to refuse life-sustaining treatment.<sup>252</sup> In its 1992 *Planned Parenthood of Southeastern Pennsylvania v. Casey* decision, the Supreme Court affirmed that the law affords protection to personal decisions relating to contraception.<sup>253</sup> It noted that personal decisions regarding the use of contraceptives involve choices central to personal dignity and autonomy.<sup>254</sup>

Similarly, in *Cruzan v. Director, Missouri Department of Health*, the Court assumed that the liberty interest in the Due Process Clause of the Fourteenth Amendment encompassed the right to refuse life-sustaining medical treatment.<sup>255</sup> The Court also noted that the right to refuse medical treatment has been recognized by states as a common-law right to bodily integrity and self-determination, as a constitutionally protected right to privacy within state constitutions, and, in some cases, as a statutory right.<sup>256</sup> In sum, at their core, both the right to use and access contraception and the right to refuse life-sustaining treatment speak to an individual's right to self-determination and to control fundamental decisions involving his or her own body.<sup>257</sup>

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<sup>250</sup> See *id.*

<sup>251</sup> See *Casey*, 505 U.S. at 851; *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990); *Carey*, 431 U.S. at 685; *Eisenstadt*, 405 U.S. at 453-54; *Griswold*, 381 U.S. at 485-86; *Gray v. Romeo*, 697 F. Supp. 580, 585-86 (D.R.I. 1988).

<sup>252</sup> See *Casey*, 505 U.S. at 851; *Cruzan*, 497 U.S. at 278; *Carey*, 431 U.S. at 685; *Eisenstadt*, 405 U.S. at 453; *Griswold*, 381 U.S. at 485.

<sup>253</sup> 505 U.S. at 851.

<sup>254</sup> *Id.*

<sup>255</sup> 497 U.S. at 278.

<sup>256</sup> *Id.* at 277-78.

<sup>257</sup> See *Casey*, 505 U.S. at 851; *Cruzan*, 497 U.S. at 278; *Carey*, 431 U.S. at 685; *Eisenstadt*, 405 U.S. at 453; *Griswold*, 381 U.S. at 485; *Gray*, 697 F. Supp. at 585-86.

Although both are protected as fundamental rights under the U.S. Constitution, the refusal of life-sustaining treatment and the use of contraceptives are also religiously, morally, and ethically controversial.<sup>258</sup> For example, the teachings of the Catholic Church limit health care providers' ability to allow refusal of life-sustaining treatment and provide contraceptives.<sup>259</sup> Thus, guided by their own religious convictions, health care providers may oppose both withdrawing or withholding life-sustaining treatment and dispensing contraceptives in certain circumstances.<sup>260</sup> Even if a health care provider is not particularly religious, his or her conscientious objection may be based on strong ethical or moral beliefs.<sup>261</sup>

Thus, a patient's request to withdraw or withhold treatment may cause religious, moral, or ethical conflict for a health care provider in the same way that a patient's request for contraceptives does.<sup>262</sup> As a result, examining the conflict in the life-sustaining treatment context provides guidance in resolving the conflict between patients seeking to have their contraceptive prescriptions timely filled and conscientiously objecting pharmacists.<sup>263</sup>

## 2. Proposed Components of Pharmacist Refusal Clause Legislation

Both the transfer and notice requirements embraced by courts and legislatures allow the patient to exercise his or her right to self-determination by refusing unwanted medical treatment, without vio-

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<sup>258</sup> See, e.g., *Gray*, 697 F. Supp. at 583; *Morrison v. Abramovitch*, 253 Cal. Rptr. 530, 532 (Cl. App. 1988); *Bouvia v. Super. Ct.*, 225 Cal. Rptr. 297, 304 (Cl. App. 1986); *Bartling v. Super. Ct.*, 209 Cal. Rptr. 220, 222-23 (Cl. App. 1984); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 632 (Mass. 1986); *In re Jobes*, 529 A.2d 434, 437 (N.J. 1987); *In re Requena*, 517 A.2d 886, 888-89 (N.J. Super. Ct. App. Div. 1986), *aff'd*, 517 A.2d 869 (N.J. Super. Ct. Ch. Div. 1986); *Elbaum v. Grace Plaza of Great Neck, Inc.*, 544 N.Y.S.2d 840, 843 (App. Div. 1989); *Delio v. Westchester County Med. Ctr.*, 516 N.Y.S.2d 677, 680 (App. Div. 1987); ETHICAL DIRECTIVES, *supra* note 113, §§ 52, 56-59.

<sup>259</sup> See ETHICAL DIRECTIVES, *supra* note 113, §§ 52, 56-59.

<sup>260</sup> See *id.*

<sup>261</sup> See, e.g., *Brophy*, 497 N.E.2d at 632; *Jobes*, 529 A.2d at 437; *Delio*, 516 N.Y.S.2d at 680.

<sup>262</sup> See, e.g., *Gray*, 697 F. Supp. at 583; *Morrison*, 253 Cal. Rptr. at 532; *Bouvia*, 225 Cal. Rptr. at 304; *Bartling*, 209 Cal. Rptr. at 222-23; *Brophy*, 497 N.E.2d at 632; *Jobes*, 529 A.2d at 437; *Requena*, 517 A.2d at 888-89; *Elbaum*, 544 N.Y.S.2d at 843; *Delio*, 516 N.Y.S.2d at 680.

<sup>263</sup> See, e.g., ALA. CODE § 22-8A-8(a) (LexisNexis 1997); CAL. PROB. CODE § 4736 (West Supp. 2005); COLO. REV. STAT. § 15-14-507(1), (2) (2004); CONN. GEN. STAT. ANN. § 19a-580a (West 2003); FLA. STAT. ANN. § 765.1105 (West 2005); KY. REV. STAT. ANN. § 311.633(2), (3) (LexisNexis 2001); N.J. STAT. ANN. § 26:2H-65 (West 1996); N.Y. PUB. HEALTH LAW § 2984(3), (4) (McKinney 2002); S.D. CODIFIED LAWS § 34-12D-11 (2004); TENN. CODE ANN. § 32-11-108(a) (2001); *Gray*, 697 F. Supp. at 590-91; *Brophy*, 497 N.E.2d at 639; *Requena*, 517 A.2d at 870.

lating the religious, moral, or ethical integrity of the objecting health care provider.<sup>264</sup> A notice requirement gives patients and their families advance knowledge of a health care provider's policy regarding life-sustaining treatment, notifying patients that they cannot rely on that facility to fulfill their wishes and enabling patients to find another provider if they so choose.<sup>265</sup> A transfer requirement ensures that the patient's wishes will be carried out in the event the health care provider refuses the patient's request.<sup>266</sup>

Imposing similar duties on pharmacists who conscientiously object to filling prescriptions for contraceptives would provide for a compromise between the two competing interests of the patient and the objecting pharmacist.<sup>267</sup> A transfer requirement for pharmacists who conscientiously object to dispensing contraceptives would allow a pharmacist to maintain his or her ethical integrity while ensuring that a woman is able to exercise her fundamental right to self-determination in choosing to use contraceptives.<sup>268</sup> The APhA's testimony to the House Small Business Committee notes that pharmacies already commonly use such systems in order to accommodate the objecting pharmacist's beliefs while still allowing the woman to access contraceptives.<sup>269</sup>

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<sup>264</sup> See ALA. CODE § 22-8A-8(a); CAL. PROB. CODE § 4736(b); COLO. REV. STAT. § 15-14-507(1), (2); FLA. STAT. ANN. § 765.1105; KY. REV. STAT. ANN. § 311.633(2); N.Y. PUB. HEALTH LAW § 2984(3), (4); *Gray*, 697 F. Supp. at 590-91; *Brophy*, 497 N.E.2d at 639; *Jobs*, 529 A.2d at 450; *Requena*, 517 A.2d at 870; *Elbaum*, 544 N.Y.S.2d at 847-48.

<sup>265</sup> See, e.g., COLO. REV. STAT. § 15-14-507(1); FLA. STAT. ANN. § 765.1105(1)(b); N.J. STAT. ANN. § 26:2H-65(b); N.Y. PUB. HEALTH LAW § 2984(3)(a); *Gray*, 697 F. Supp. at 590-91; *Jobs*, 529 A.2d at 450; *Requena*, 517 A.2d at 870; *Elbaum*, 544 N.Y.S.2d at 847-48; 42 C.F.R. § 489.102(a)(1), (b)(1), (2) (2004).

<sup>266</sup> See, e.g., ALA. CODE § 22-8A-8(a); CAL. PROB. CODE § 4736(b); CONN. GEN. STAT. ANN. § 19a-580a; KY. REV. STAT. ANN. § 311.633(2); S.D. CODIFIED LAWS § 34-12D-11; TENN. CODE ANN. § 32-11-108(a); *Gray*, 697 F. Supp. at 591; *Brophy*, 497 N.E.2d at 639; *Elbaum*, 544 N.Y.S.2d at 848.

<sup>267</sup> See ALA. CODE § 22-8A-8(a); CAL. PROB. CODE § 4736; COLO. REV. STAT. § 15-14-507(1), (2); CONN. GEN. STAT. ANN. § 19a-580a; FLA. STAT. ANN. § 765.1105; KY. REV. STAT. ANN. § 311.633(2); N.J. STAT. ANN. § 26:2H-65; N.Y. PUB. HEALTH LAW § 2984(3), (4); S.D. CODIFIED LAWS § 34-12D-11; TENN. CODE ANN. § 32-11-108(a); *Gray*, 697 F. Supp. at 590-91; *Brophy*, 497 N.E.2d at 639; *Jobs*, 529 A.2d at 450; *Requena*, 517 A.2d at 870; *Elbaum*, 544 N.Y.S.2d at 847-48.

<sup>268</sup> See ALA. CODE § 22-8A-8(a); CAL. PROB. CODE § 4736(b); CONN. GEN. STAT. ANN. § 19a-580a; KY. REV. STAT. ANN. § 311.633(2); S.D. CODIFIED LAWS § 34-12D-11; TENN. CODE ANN. § 32-11-108(a); *Casey*, 505 U.S. at 851; *Carey*, 431 U.S. at 685; *Eisenstadt*, 405 U.S. at 453; *Griswold*, 381 U.S. at 485; *Gray*, 697 F. Supp. at 591; *Brophy*, 497 N.E.2d at 639; *Elbaum*, 544 N.Y.S.2d at 848.

<sup>269</sup> *Hearing, supra* note 194, app. at 62.

For example, a transfer requirement could require the pharmacist who objects to dispensing contraceptives to avoid doing so by transferring the prescription to another pharmacist within the same pharmacy who does not object to dispensing contraceptives.<sup>270</sup> To facilitate this process and ensure access to contraceptives that must be taken within a few days of being prescribed, pharmacies would be required to have on staff at all times a pharmacist willing to dispense contraceptives.<sup>271</sup> If, however, this is not possible because there are no other pharmacists within the pharmacy willing to dispense contraceptives, the pharmacist would then be required to transfer the customer's prescription to a different pharmacy that is willing to dispense contraceptives.<sup>272</sup>

A requirement that pharmacies have at least one pharmacist on staff at all times willing to dispense contraceptives may be especially important in rural areas where there may be no pharmacy within a short distance.<sup>273</sup> Emergency contraception, in particular, must be taken within seventy-two hours to be most effective in preventing pregnancy.<sup>274</sup> If transferring to another pharmacy would result in a delay of more than seventy-two hours before the patient could take the medication, the medication would become ineffective in preventing pregnancy.<sup>275</sup>

Pharmacists and pharmacies conscientiously objecting to dispensing contraceptives should also be required to notify their customers of their policy so that customers will not mistakenly rely on a pharmacist's or pharmacy's willingness to dispense contraceptives.<sup>276</sup> A notification requirement would require an individual pharmacist who conscientiously objects to dispensing contraceptives to inform his or her employer of such objections before he or she is permitted to refuse to fill any prescriptions.<sup>277</sup> This would enable the employer to de-

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<sup>270</sup> See *id.*

<sup>271</sup> See *id.*

<sup>272</sup> See *id.*; Cantor & Baum, *supra* note 241, at 2011; Cohen, *supra* note 198, at 2-3.

<sup>273</sup> See Cantor & Baum, *supra* note 241, at 2010-11; Cohen, *supra* note 198, at 2-3.

<sup>274</sup> APHA REPORT, *supra* note 197, at 12; Cantor & Baum, *supra* note 241, at 2010; Cohen, *supra* note 198, at 2.

<sup>275</sup> See APHA REPORT, *supra* note 197, at 12; Cantor & Baum, *supra* note 241, at 2010; Cohen, *supra* note 198, at 2.

<sup>276</sup> See COLO. REV. STAT. § 15-14-507(1) (2004); FLA. STAT. ANN. § 765.1105(1)(b) (West 2005); N.J. STAT. ANN. § 26:2H-65(b) (West 1996); N.Y. PUB. HEALTH LAW § 2984(3)(a), (4) (McKinney 2002); Gray, 697 F. Supp. at 590-91; *Jobes*, 529 A.2d at 450; *Requena*, 517 A.2d at 870; *Elbaum*, 544 N.Y.S.2d at 847-48; 42 C.F.R. § 489.102(a)(1), (b)(1), (2) (2004).

<sup>277</sup> See CAL. BUS. & PROF. CODE § 733(b)(3) (West 2006).

velop a system so that the pharmacist's objection could be accommodated without burdening any customers.<sup>278</sup> For example, California requires the pharmacist to notify his or her employer, in writing, of the drugs that he or she objects to dispensing, before the pharmacist is permitted to conscientiously refuse to dispense these drugs.<sup>279</sup> The pharmacy must then establish alternate means to ensure that the customer receives her prescriptions in a timely manner.<sup>280</sup>

Additionally, a notice requirement as applied to pharmacies would require pharmacies that choose not to stock contraceptives to notify potential customers by displaying a sign that clearly indicates that they do not provide contraceptives.<sup>281</sup> With such notification, customers would know prior to filling certain prescriptions that they cannot rely on this particular pharmacy.<sup>282</sup> Thus, they would be able to find an alternate pharmacy before they need the particular medication, avoiding a conflict with that pharmacy, and balancing their rights against those of the pharmacy.<sup>283</sup>

### CONCLUSION

Refusal clauses were first enacted to ensure health care providers would not be forced to perform certain reproductive services, such as abortion, to which they were religiously, morally, or ethically opposed. Several factors, such as the growth of religious health care organizations and managed care, as well as the development of controversial medical technology, have led states to expand health care provider refusal laws. In particular, pharmacists, who are not protected under

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<sup>278</sup> See *id.*

<sup>279</sup> *Id.*

<sup>280</sup> *Id.*

<sup>281</sup> See Cantor & Baum, *supra* note 241, at 2011. In March 2006, Wal-Mart, which up until that point was the last large pharmacy chain to decline to carry emergency contraception, announced that it will begin to stock the Plan B contraceptive in its pharmacies. See Press Release, Wal-Mart, Wal-Mart to Carry Plan B Emergency Contraception (Mar. 3, 2006), available at <http://www.walmartfacts.com/articles/1704.aspx>.

<sup>282</sup> See COLO. REV. STAT. § 15-14-507(1) (2004); FLA. STAT. ANN. § 765.1105(1)(b) (West 2005); N.J. STAT. ANN. § 26:2H-65(b) (West 1996); N.Y. PUB. HEALTH LAW § 2984(3)(a) (McKinney 2002); *Gray*, 697 F. Supp. at 590-91; *Jobes*, 529 A.2d at 450; *Requena*, 517 A.2d at 870; *Elbaum*, 544 N.Y.S.2d at 847-48; 42 C.F.R. § 489.102(a)(1), (b)(1), (2) (2004); Cantor & Baum, *supra* note 241, at 2011.

<sup>283</sup> See COLO. REV. STAT. § 15-14-507(1); FLA. STAT. ANN. § 765.1105(1)(b); N.J. STAT. ANN. § 26:2H-65(b); N.Y. PUB. HEALTH § 2984(3)(a); *Gray*, 697 F. Supp. at 590-91; *Jobes*, 529 A.2d at 450; *Requena*, 517 A.2d at 870; *Elbaum*, 544 N.Y.S.2d at 847-48; 42 C.F.R. § 489.102(a)(1), (b)(1), (2); Cantor & Baum, *supra* note 241, at 2011.

most abortion and contraception refusal clauses, have pushed for a right to conscientiously object to dispensing contraception.

A few states have explicitly addressed a pharmacist's right to conscientiously object. Most of this current legislation, however, fails to balance adequately a pharmacist's right to conscientiously object against a woman's right to access contraceptives. Court decisions and legislation addressing a similar conflict between health care providers and patients' refusal of life-sustaining medical treatment provide guidance for future pharmacist refusal laws. The transfer and notice requirements imposed on conscientiously objecting health care providers in the life-sustaining treatment context should likewise be imposed on pharmacists who conscientiously object to dispensing contraceptives. This approach best balances the rights of both pharmacist and patient.

NATALIE LANGLOIS